



# Nota Bene

TAKE NOTE OF THIS

A PUBLICATION FOR THE MEDICAL STAFF OF KENNEDY HEALTH SYSTEM

## A Message From the President

In May, Kennedy underwent its triennial AOA survey. This summer, we were surveyed by the New Jersey Department of Health & Senior Services as contract agents for a full Medicare survey, and we anticipate the Joint Commission survey team to visit Kennedy before the end of the year.

The verbal reports by the survey teams at the closing conferences have been positive. The surveyors have visited Kennedy in years past, and have noted progress we've made in improving the quality of patient care. I know that preparing for these surveys takes an enormous amount of time. It is a team effort that requires everyone's cooperation and participation. I thank you for your hard work during the survey process, and for your continued support in keeping us "survey ready" on a daily basis.

With all of the regulations, it is sometimes difficult to remember that that primary goal of these surveys is to assure that patients receive excellent care in a safe environment by competent practitioners. You are key to helping Kennedy provide our patients with the finest, most effective and efficient healthcare.

Although we have made progress in improving patient satisfaction scores, more work must be done and patient satisfaction continues to be a priority. Measures are being taken to ensure that everyone understands the importance of treating our patients and their families with sensitivity and respect. "Treating You Well" is not just a slogan – it's Kennedy's promise to our community.

The economy, while improving, has not fully recovered from the recession. Like many other healthcare organizations, Kennedy is affected by this economic downturn. We now treat more patients who have lost both their jobs and their health coverage. Nonetheless, we continue to care for all patients who come to our Emergency Departments, regardless of their ability to pay. In addition, the federal and state governments have cut funding for some of our programs, reducing our revenue streams and creating a substantial financial burden.

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## New Appointments

### Department of

#### Internal Medicine

Stephen Szawlewicz, MD  
*General Internal Medicine*

### Department of

#### Medical Imaging

John Glassburn, MD

#### *Telemedicine*

Suzanne Aquino, MD

David K. Bass, MD

Rachel H. Braunstein, MD

David D. Burdette, MD

Susan A. Dinges, MD

Donald A. Eckard, MD

Valerie R. Eckard, MD

Jon Engbretson, MD

Jason E. Grennan, MD

Laurie L. Gutstein, MD

George F. Knight, MD

Thomas W. Pettinger, MD

Jorge Alberto Ramirez, MD

Carl A. Recine, MD

Douglas W. Rusnack, MD

Bradley Jay Snyder, MD

Jerry R. Thomas, MD

### Department of Surgery

Harry Cantrell, MD

*Otorhinolaryngology*

Roy Carlson, MD

*Otorhinolaryngology*

Stephen P. Gadomski, MD

*Otorhinolaryngology*

Ashmit Gupta, MD

*Otorhinolaryngology*

Shelly Levulis, DPM

*Podiatry*

## Physicians in the News

**Eduardo Careaga, MD**, has joined Kennedy as a breast surgeon. Dr. Careaga graduated from Florida International University Honors College in 1995 and received his medical degree from UMDNJ-Robert Wood Johnson Medical School in 2008. He recently completed a Breast Surgery Fellowship at the Comprehensive Cancer Center at The Bryn Mawr Hospital. Fluent in both Spanish and English, Dr. Careaga will be based at the Kennedy Cancer Center in Washington Township. To make a referral, call 856/218-2100.



**Eric Grossman, MD**, has opened a new OB/GYN office in Turnersville, NJ, located at University Executive Campus, 151 Fries Mill Rd., Suite 105. Phone: 856/302-6266. Dr. Grossman and his partner Roberta Felsenstein, MD, also share an office in Voorhees.

**Craig Wax, DO**, was recently elected to the *Medical Economics* physician editorial board. Dr. Wax is a family physician practicing in Mullica Hill, NJ, and also the host of "Your Health Matters" on Rowan Radio.

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### A Message from the President *continued from page 1*

We are taking a number of steps to help Kennedy weather this economic storm, including initiatives to assure that our billing and collections are accurate and that our expenses are monitored and well-managed. We rely on our bottom line to fund investments in our physical plant, technology, salaries and benefits. Maintaining a healthy balance sheet is necessary to keep Kennedy strong. Your support in meeting our objectives is essential to our future success.

Finally, as we move into the fall season, I encourage you to get vaccinated for seasonal flu. Free vaccinations will be available to you through our Infection Control Team. Also, please remember that proper hand hygiene is our best defense against the spread of the flu and other diseases.

I appreciate your hard work and commitment to making Kennedy the best we can be.

Sincerely,

Martin A. Bieber  
*President & CEO*  
*Kennedy Health System*

# What Does Health Reform Mean to Kennedy Physicians?

by David Shulkin, MD – From the Office of the Chief Medical Officer

With the intense public focus on healthcare, it is overwhelming for most people to get a solid feel on where our medical system is heading. While no one, including me, can predict with accuracy what the outcome of this debate will be, there does seem to be some reasonable certainties of what is likely to occur. To understand how all of this will impact Kennedy, let's first examine the main thrust of the policies underlying healthcare reform. President Obama has prioritized insurance coverage for most Americans. This means that up to an additional 45 million Americans will need medical coverage. While a noble goal, this is clearly an expensive proposition. Therefore, much of the attention of the debate has been on the cost of expanding access to care, and if it proceeds, how to pay for it.

Let's look at how changes in healthcare reimbursements may impact Kennedy, first by examining some of the potential responses by each of the major groups involved in our healthcare system.

First are the **insurance companies**, or as some call them, the payors. Some payors are beginning to respond to the cost crisis by innovating with products called Value-Based Insurance Design (VBID). VBID provides a healthcare benefit that costs less when the service is thought to add additional value or quality to the patient and pays less when the benefit is considered to be less beneficial. United Healthcare recently launched an innovative product called the "Diabetes Health Plan" that has lower deductibles for use of statins, hypoglycemic, and recommended laboratory testing. We are likely to see more such products enter the market in the near future.

Second, is the **government**. Both federal and state governments have taken the lead role in mandating data collection, such as HCPAHS, Core Measures, Infection Rates, and Patient Safety indicators, which serve as a basis for helping consumers make better healthcare decisions. Government is likely to continue to promote pay-for-performance programs which reward providers who demonstrate improved quality and reduced cost. There is also good reason to believe that government is likely to use bundled payments for services – which are designed to be shared among physicians, hospitals, and other providers, such as long-term care facilities. Government payment systems are likely to shadow the public policy debate in reform that seems to be pointing towards more integrative systems of care, care coordination, and accountability for quality and cost.

Third, are the **patients** themselves. Employers are encouraging employees to use value-based judgments in selecting healthcare, as well as creating new vehicles for their employees in the form of health savings accounts and providing more information on provider performance. The introduction of new software systems, along with the widespread dissemination of technology, now allow consumers to have improved access to information on provider performance. Better informed consumers help reduce costs and improve healthcare value.



# Process for Applying for Physician Courtesy Discounts

The Courtesy Discount Policy for medical staff members, spouses and dependent children gives Kennedy the right to waive all co-payments and deductibles provided that the aggregate annual discount does not exceed the \$1,000.

This policy was written in accordance with all applicable laws and regulations including the Federal Anti-Kickback law, the Stark law and the State of New Jersey. Please note that the discount is offered without regard to patient referrals or other business generated between Kennedy and the physician/covered family member(s).

If you want to apply for the courtesy discount, please submit the following documents via fax to **Jeannie Madosky**, Corporate Director, Physician Relations. The fax number is **856/582-2519**.

- Kennedy Hospital billing statement
- Copy of your insurance card – front and back
- Insurance company statement including explanation of benefits (EOB)
- Relationship of the qualified dependent to you, if you are not the recipient of the service(s)

Ms. Madosky will collate all of the required forms/documents and send to **Joseph Lario**, Kennedy Health System Sr.VP/Chief Financial Officer for review.

As a reminder, here are the major points of the policy:

- The policy only applies to active or consulting medical staff members, spouses and dependent children for services or items provided by Kennedy University Hospital (KUH) campuses.
- The courtesy discounts only apply to health care services or items that are routinely provided by KUH and are deemed medically necessary by the patient's insurer. Patient convenience items are excluded.
- The individual receiving the discount must comply with the insurer's medical management policies and procedures.
- Cosmetic surgery services and procedures are NOT eligible for discounts.
- Physicians, their spouses and dependent children can petition the elected Medical Staff Officers for financial support from the medical staff dues account for an unpaid medical claim either not eligible for this discount or for a remaining balance after the discount has been applied. A hardship care will be pursued confidentially by the requesting party with the Kennedy Health System Chief Financial Officer, Sr.VP/CMO, or President of the Medical Staff.

# Educating Patients Before Discharge Reduces Readmissions

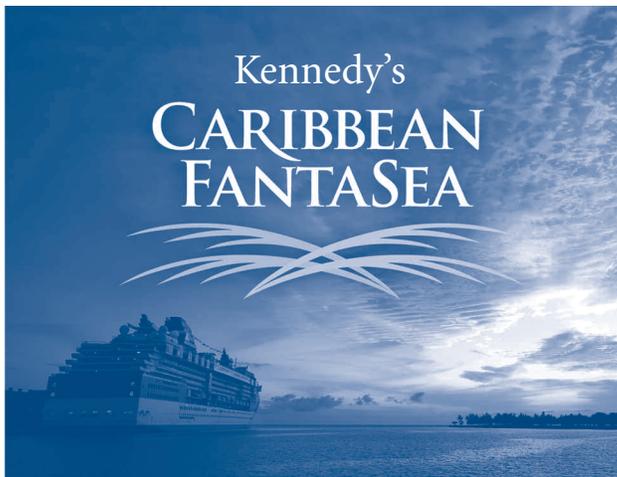
Patients being readmitted within 30 days of discharge is a nation-wide problem and an indication of a care process failure. A recent study funded by the Agency for Healthcare Research and Quality (AHRQ) found that patients who have a good understanding of their “after-hospital care” instructions are 30% less likely to be readmitted or go to the Emergency Department than patients who are not given clear, complete information they can understand.

Kennedy is currently participating in a regional collaborative designed to reduce preventable readmissions. Activities are now under way to develop an internal plan designed to identify patients who are at high risk for readmissions. Major components of this initiative includes ways to:

- Standardize educational materials across the continuum of care
- Accurately perform the medication reconciliation process
- Facilitate follow-up appointments of high risk patients with physicians prior to patient discharge
- Improve healthcare referrals to home care
- Improve communication between caregivers when patients are transferred from one level of care to another

Physicians are “key” to the discharge instruction process. In order to assist you, we have developed a comprehensive discharge instruction sheet and remind you to use this as a guide whenever you are educating your patients about after-hospital care and follow-up.

We will keep you informed as we move forward with this initiative!



## Take a Cruise Abroad on Broad!

**The Annual Kennedy Gala will be held on February 27, 2010, at the Park Hyatt Philadelphia at the Bellevue.**

Mark your calendars for another exciting social event!

# Clinical Documentation Improvement Program (CDIP)

As the correlation between clinical records, quality indicator reporting, direct financial reimbursement, and financial incentives grows, the importance of having solid clinical documentation processes increases. Kennedy has developed a Clinical Documentation Improvement Program (CDIP) to help protect physicians from the negative impact of incomplete physician documentation. One component of this program is to provide you with information regarding problematic documentation issues. Below are some documentation tips to assist you in providing the most specific diagnoses and procedures. To further assist you,

Clinical Documentation Specialists will be on the patient care units performing record reviews while the patient is still in-house. If further clarification is necessary for appropriate assignment of diagnoses and procedures, you will be asked to provide clarification in the progress notes or on a query form.

Remember, complete documentation the first time around will reduce the number of queries that are placed on the chart for your review and completion. If you have any questions, please call **Ellen Lammerding**, Coding Quality Coordinator, at **856/488-6522**.

**DOCUMENTATION 'KWIK' TIPS** – Document clearly and legibly every condition that is impacting the patient's stay including chronic conditions needing treatment, evaluation/monitoring.

**Professional fee (E&M) coding** – Requires symptoms or confirmed diagnoses – “Rule- out” is not acceptable

**Hospital (DRG) coding** – Based on the diagnoses under investigation. “Rule-out,” “probable,” “suspected” conditions are acceptable & should be documented. Any conditions that are ruled out after work up must be clearly documented as “ruled out.”

**It is possible to abide by both DRG and pro-fee guidelines, for example:** “Diarrhea: likely viral gastroenteritis; R/O partial SBO.”

## INTERPRETATION –

*Coders cannot interpret testing results or clinical observations. Diagnoses related to abnormal exam findings, IM/Path/Lab results, need to be clearly documented in progress notes by treating physician/LIP.*

## INSTEAD OF...

▼ NA  
Hgb = 5.2; transfuse  
LUL infiltrate  
▲temp, ▼breath sounds, CXR,  
begin incentive spirometry  
Wound red and indurated, IV antibx  
Abdomen distended; NPO, NG placed

## DOCUMENT SPECIFIC DIAGNOSIS/CONDITION

Patient is hyponatremic with NA of 120  
Acute blood loss anemia  
Bacterial pneumonia (specify causative organism)  
  
Atelectasis  
Cellulitis  
Ileus

## ETIOLOGY, CAUSE & EFFECT –

*Coders cannot assume etiology or underlying cause of a condition. Document cause or probable cause of conditions/symptoms. Avoid use of symptoms as principal diagnosis if underlying cause is known or suspected. Link manifestations to underlying condition.*

## INSTEAD OF...

Chest pain  
  
Syncope  
SOB  
  
Abdominal pain  
Unable to void; insert Foley  
Urine output, will bolus with IV fluids  
DM; PVD  
Pneumonia; +strep  
HTN; heart disease

## IDENTIFY CAUSE OR PROBABLE CAUSE

Type of angina; Type of suspected GI disturbance causing chest pain  
Specific arrhythmia causing syncope  
Type of COPD; Suspected type of pneumonia (aspiration, bacterial, etc)  
Suspected etiology, ex: “Abdominal pain: R/O cholecystitis”  
Urinary retention  
Volume depletion; dehydration  
Diabetic PVD  
Bacterial pneumonia due to strep  
Hypertensive heart disease

## SPECIFICITY –

*Document degree, acuity, stage and type.*

## INSTEAD OF...

Ulcer  
Anemia  
Urosepsis  
  
Unresponsive  
Obesity  
CHF

## BE SPECIFIC

Document site & stage – “3rd degree pressure ulcer of calf”  
“chronic iron deficiency anemia” ; “acute blood loss anemia”  
UTI with bacteremia; systemic sepsis (do not document “urosepsis”)  
Coma if in fact patient is comatose  
Obesity; BMI > 40  
Acute vs. chronic; diastolic vs. systolic or combined

# Women and Addiction

By John Pellicane, Case Management Specialist

“Substance abuse and addiction is by far the number one women's health problem, causing illness, injury and death and contributing to a whole host of related social problems.”<sup>1</sup>

Not long ago, I came in contact with a woman who suffered greatly as a result of alcohol abuse. She was a well-respected employee with a responsible position. No one ever suspected she had a problem. After a major loss in her life, her job performance slowly began to change – even becoming erratic. Colleagues questioned her well-being, but with so few facts, there was little that could be done. When her co-workers began to smell alcohol on her breath, everything seemed to make sense – she had an alcohol problem. She was given multiple warnings and opportunities to get help, but did not take advantage of them. Never seeming to realize the extent of her own illness, she ultimately lost her job -- a sad end to a 20-plus-year career. Her circumstances shed light on a growing problem: women and addiction.

For the last 20 years, the rate of substance abuse among women rapidly increased faster than men. Statistics reveal even more alarming and disturbing trends: teenage girls today are drinking and abusing drugs as often as teenage boys .

When members of our society become impaired, the health of the individual, family, workplace and community suffer. Although it is difficult to measure the full extent of the damage caused by alcohol abuse, the negative effects can linger for years. In general, we know that women with a drinking problem:

1. Become intoxicated faster than men
2. Become clinically “addicted” more rapidly
3. Are more likely to be diagnosed with mental health disorders (e.g., depression) with a subsequent co-occurring disorder
4. Face a greater stigma than an addicted man
5. Are less likely than men to receive the social and family support for getting into treatment
6. Are 50% more likely to die from a substance abuse related disorder
7. Represent only 25% of those in treatment, but account for 40% of those addicted

The good news – women in treatment relapse less frequently than men. Kennedy’s Behavioral Health Services successfully treated women from many backgrounds for more than two decades. Our experienced and professional staff has the expertise necessary meet the needs of this very significant population. We can help teach the skills to build the foundation that will help our patients embark on a lasting recovery. For more information, please contact the **ACCESS Center** at **800/528-3425**.

1. <http://www.encognitive.com/files/Substance%20Abuse,%20Addiction%20&%20Women.pdf>

Finally, let's look at the response of the **provider community**. Many physician and hospital organizations are examining ways to organize themselves to promote better use of resources. Through electronic connectivity and defined protocols of care, providers can avoid duplication of testing and implement evidence-based protocols. Some organizations, like Intermountain Health Care in Utah, the Geisinger Clinic in Danville, PA, and the Cleveland Clinic, have received national attention for their efforts to coordinate care and reduce unnecessary services. These systems are being defined as "Accountable Care Organizations," in which the providers organize care systems to promote improved outcomes and better value for care.

Clearly, there are many "moving pieces" in understanding where healthcare is headed. We are likely to see much additional innovation by each of the stakeholder groups in coming months. Kennedy, too, is involved in extensive strategic work to respond to these challenges. To not undergo introspection and strategic thinking at this time would be a mistake. The clear result of doing nothing will simply be an imposed reduction in fee schedules, without any system reform or redesign and this would clearly be a missed opportunity.



**Nota Bene**  
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of the Kennedy  
Health System

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