INSIGHTS
A NEWSLETTER FOR OVERLOOK MEDICAL CENTER PHYSICIANS

PALLIATIVE CARE AND POLST AT OVERLOOK

Everyone seems to know what hospice is, but palliative care is often seen as an interchangeable term. There's an important difference, however. Palliative care is not exclusively for those reaching the end of their lives. Many patients who get palliative care may still have years to live, and Overlook Medical Center's palliative care team is there to improve the quality of life for those with a serious illness.

"We may see a brand new diagnosis of pancreatic cancer, and the patient needs help with advanced care planning," said Jeanne Kerwin, DMH, CT, ethics and palliative care coordinator at Overlook. "We try to introduce ourselves early to make the treatment and existence with the disease as easy as it can be."

The palliative care team helps guide families with decision-making that's in keeping with the patient's preferences, preserving the best quality of life concurrently with receiving medical care.

The palliative care team talks with the patient and family about their needs, to treat the whole person, not just the disease. They collaborate with social workers to determine where the resources will come from. "We try to keep the patient at the center of decision-making, especially if the patient has expressed preferences, we want those carried out," Kerwin said.

The palliative care team tries to focus the family on keeping the patient in charge, whether or not the patient has an advanced directive.

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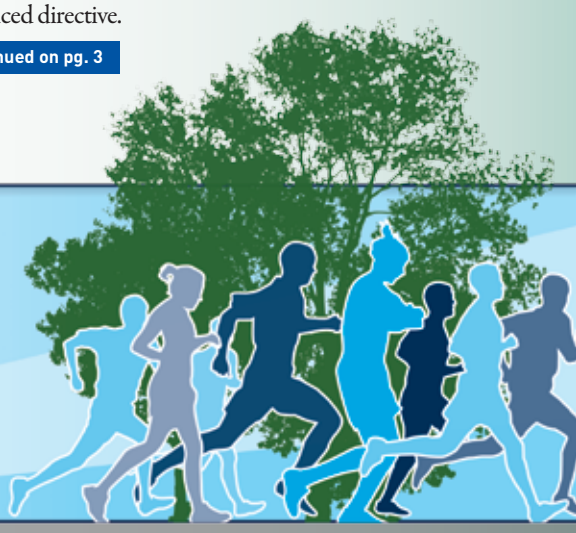
Overlook Medical Center ATLANTIC HEALTH SYSTEM 5K

Lace up your running shoes for the Overlook Medical Center 5K. This race benefits the Summit Police Activity League (PAL), a nonprofit charity focused on Summit's youth, and also the Atlantic Neuroscience Institute Brain Aneurysm Fund. The run is USATF certified/sanctioned, and takes place on Tuesday, June 26 at 7 p.m. at the Summit Village Green. To register, visit http://overlook5k.com/.



Inside

Overlook Medical Center ATLANTIC HEALTH SYSTEM

MISSION STATEMENT

- Deliver high-quality, safe, affordable patient care within a healing culture
- Educate in an exemplary manner present and future members of the healthcare profession
- Innovate through leadership
- Improve the health status of the communities we serve

Overlook Medical Center's Business Development/Physician Relations department is here to help you. As healthcare delivery becomes more and more challenging and complex, we are committed to working together. We are your resource whether it is the need for space, transition/retirement planning, or practice expansion and physician recruitment. Our database includes graduating residents and fellows who are interested in joining private practices, as well as physicians who are reaching the point of transition in their careers.

With increased communication and networking we will reach our goals together.

Contact us at ext. 5907 for more information.

Insights is published by the Physician Relations/Business Development office of Overlook Medical Center. It is mailed to every physician on staff and is available via e-mail. We are driven by submissions and feedback from our physicians. Ideas and suggestions for upcoming issues are welcome. Please e-mail all submissions, comments, and corrections to Thomas.Quigley@atlantichealth.org.

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A MESSAGE FROM THE MEDICAL DIRECTOR

One of the things coming to my attention a lot lately is the need to improve physician-patient communication. In addition to improving care and satisfying our patients' needs, this is a metric CMS and other payers are using as part of value-based purchasing payment plans.

With pressures to accomplish a lot of the care process in a compressed time frame, we sometimes compromise the time spent on effective communication. While a patient may feel the physician is highly skilled, they also feel that their questions and understanding about the plan of care are deflected or deferred. They don't understand all of the work the physician does out of the patient's sight, and are confused about the multiplicity of care givers who attend them. We know there is truth in this based on Press Ganey and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, and communication often lies at the heart of patient complaints. It is unfortunate, when I review these complaints, that the care was appropriate but the perception of care is poor because of communication issues.

Going forward, up to 30% of the at-risk value-based purchase dollars hinge on patient satisfaction reporting. I believe that physicians intend to and want to communicate effectively. Since we are going to be measured by patient perception of care, we need to consider options for better communication. Some simple things to consider: identify to the patient who we are, our relationship to the other physician care givers, where the patient is in the plan of care, and asking patients how they are doing and how they feel their care plan is progressing. A frequent comment from patients is wanting to know who is in charge, and who is coordinating their care.

Sincerely,
Dr. Norm Luka

A MESSAGE FROM THE PRESIDENT OF THE MEDICAL STAFF

At Overlook Medical Center, we pride ourselves on providing excellent care. As we strive to continuously improve, we're introducing new initiatives to ensure that our patients receive better and faster care.

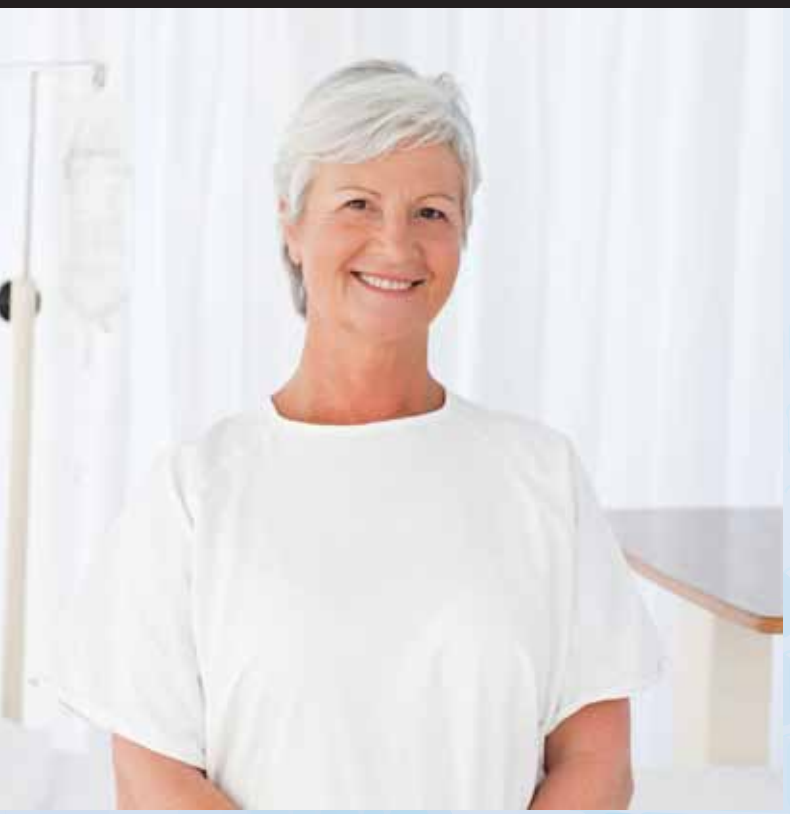
Patients admitted to the hospital are sicker than ever before, and as a result, they require closer monitoring over the first 24 to 48 hours in the hospital. In order to ensure that our patients get the best care possible, we are piloting a project to obtain vital signs every four hours for newly admitted patients, and this will be expanded hospital-wide in the near future. This will enable us to detect changes in a patient's clinical status earlier, resulting in improved outcomes.

Another initiative is computerized provider order management (CPOM). As we know, doctors have never been known for legible handwriting. Having the unit secretary enter our handwritten orders into the CPOM system, as is the current practice, increases the potential for medication errors, and slows the implementation of our orders. Over the next several months, we will transition to entering our own orders into the CPOM system. In the past the system has not been as user-friendly as we'd like. For the past 18 months, the CPOM User Group, comprised of Overlook physicians who have been early CPOM adopters, have been working to improve it. The addition of admission order set iForms, diet orders, common lab order sets, and many more, are helping to make CPOM easier to use.

Another component of our quality improvement plan is to initiate the plan of care as early as possible. In order to accomplish this goal, we are requesting that admission orders be written shortly after making the decision to admit. We are also requiring admitting physicians, or their designees, to see patients in a timely manner, based on the severity of the patient's illness. While this is frequently being done, we want to ensure that this becomes standard practice at Overlook.

We all share the common goal of providing the best possible care to our patients, and we appreciate your cooperation as we introduce these new initiatives. We know that change can be difficult, but in the end, we believe that these changes will increase the quality, efficiency and timeliness of patient care.

Sincerely,
Robert Sussman, MD



WHAT HAPPENS IN PALLIATIVE CARE?

The palliative care team works from physician referrals, which can be influenced by the patient's family, hospital nurses, and social workers, who might assess that a patient has unaddressed pain and suffering, or a conflict in family opinion on how to handle the care. Patients are often referred if the physician believes the patient will not live more than a year. Palliative care can also be considered if the patient is suffering substantially, admitted repeatedly to the hospital, or if there's a conflict about the care goals.

Kerwin explained that the palliative care team talks with the attending physician before meeting with the family. For some physicians, referral for this expertise is essential because not all doctors are comfortable discussing end-of-life care. If a physician is not planning to refer to palliative care, and is comfortable having an end-of-life conversation, it's vital to actually do so. This dialogue can be lengthy, and the physician would need to be sure there's ample time during the appointment for it. If it's not something the physician is comfortable doing, a referral to palliative care is appropriate.

Time is often cited as a reason that physicians don't broach the topic. It isn't a conversation you can have quickly. "If they're there for their 15 minute cardiac follow-up, and you invite this conversation, you can't leave the patient after 15 minutes," said Jeffrey Brensilver, MD, Overlook's J.E. Reeves chairman of medicine. The conversation can take an hour or more.

The initial family meeting with palliative care often runs 60 to 90 minutes. The team learns about the family and its dynamics, so they can help them as a unit to navigate the road ahead, and to understand the medical information to date. "They may have five to six specialists on the case," Kerwin said. "We talk to all the doctors, read the charts, and can summarize it in lay language in a quiet, sit-down mode that helps them understand and be able to move forward." Palliative care staff members are an addition to the treatment team, providing services concurrently with medical treatment. The same medical team continues to follow the patient, though palliative care staff will write notes and communicate verbally with them about the family's wishes or any family concerns.

The department performs about 650 initial consultations a year, plus many follow-ups. Kerwin said the service has been growing exponentially.

PALLIATIVE CARE EXPANDS

While palliative care is traditionally done in the hospital setting, it's expanding into ambulatory environments like cancer centers, as well as the emergency department (ED) said Brensilver. "Palliative practitioners are seeing patients not just when they're in the hospital, but in their own environment," he said. A physician can call to refer someone on an outpatient basis who can benefit from palliative care. Brensilver noted that oncologists are now referring more frequently, while the patient is receiving active oncologic treatment.

As for the ED, the staff is now asked to identify patients who are brought there with conditions where the appropriate care is to keep the patient comfortable, rather than the traditional default, doing everything medically possible for the patient. If the patient has no documentation of end-of-life care, the palliative care staff will help the patient establish goals. Brensilver said this pilot project has been successful so far.

POLST

New Jersey ranks among the highest in the country in terms of costs, labor and hospitalization days when treating patients in the last months of life, according to the Dartmouth Atlas of Health Care. One study showed that 32% of all Medicare funds are spent in the last two years of terminally ill patients' lives. Most of that is spent on hospital and physician fees during repeated hospitalizations.

Patients in New Jersey are getting end-of-life care that clearly doesn't benefit them, said Brensilver. Overlook is leading the way to change the culture and improve end-of-life care for patients in New Jersey. Part of this involves community outreach and working with the public to better understand the end-of-life process. It also involves working with physicians (especially inpatient specialists) to develop approaches that are more aligned with the patient's best interest.

This is a large part of the impetus for the state to enact the POLST law, which Governor Christie signed into law in December, 2011. POLST, which stands for Physician Orders for Life Sustaining Treatment, is an actionable order form that codifies the patient's end-of-life preferences. It's specifically targeted to patients with a limited life expectancy. The order form must be honored in all settings, including home care, nursing homes and hospitals. The form goes with the patient and becomes part of the medical record. "It ensures that patients and physicians can develop plans that will safeguard that patients get the care they want," said Brensilver, and helps avoid unwanted aggressive treatment.

While it's not a mandatory form, Kerwin said she hopes the tool will act as a catalyst for a conversation between patient and doctor, while the patient is still in a position to have that conversation. Patients may not know what measures might be taken during end-of-life care, such as CPR, ventilation, dialysis and feeding tubes. "Families don't know what questions to ask themselves in order to plan," said Kerwin. "They don't know what interventions will be offered to them." The form gives the patient the opportunity to choose comfort measures only, limited additional interventions or full treatment.

The POLST form will be most useful for long term care nursing home patients, said Kerwin. POLST is a statewide effort, however Kerwin is leading one of two pilot community programs, and is on the state committee developing the form. The project will also create guidelines for public education and promotion.

In this area, Overlook is working with two local nursing homes, Berkeley Heights Convalescent Center and Runnells Specialized Hospital of Union County for

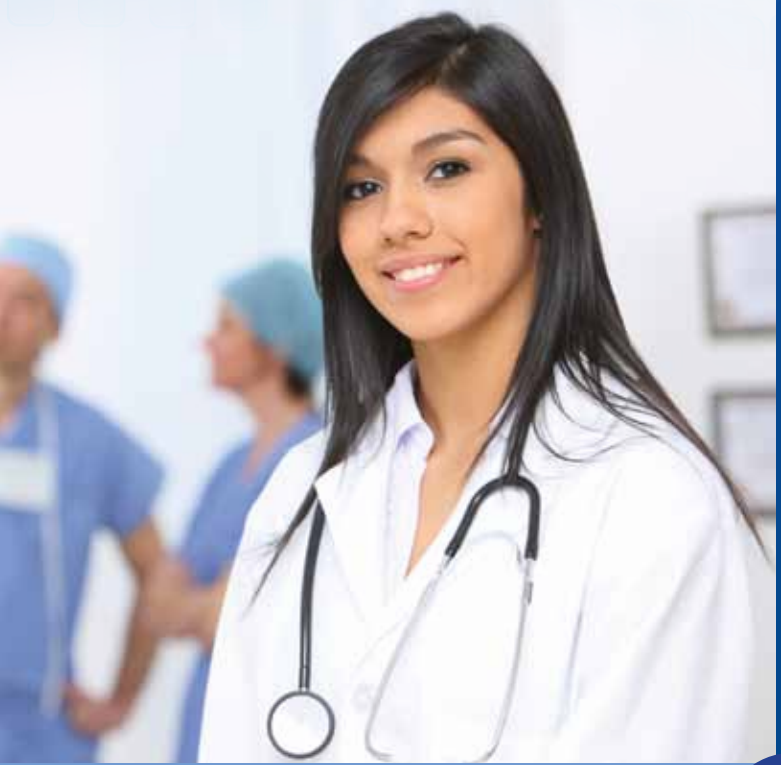
the pilot, said John Gregory, MD, director of the palliative care program at Overlook. Only patients going to and from those nursing homes are using the POLST forms, as the staff has been trained in administering them and working with patients to fill them out. Several additional nursing homes will be added soon, and the form should be standardized for the entire state by the end of 2012.

Overlook physicians will see the form in the near future. "It's seemed to be a valuable way to ensure that patients have the right conversations with physicians," Brensliver said.

Brensilver added that another major Overlook initiative is working with area nursing homes to educate and enhance those facilities' abilities to assist with end-of-life care. This includes reducing readmission rates for patients who are dying and should be kept in a more comfortable environment. They are trying to improve collaboration for patients in nursing homes who have advanced dementia and other end-of-life degenerative disorders.

POLST is not the first Overlook project bringing end-of-life care to the forefront. Kerwin and the palliative care team created the award-winning Anna's Story, a 22-minute dramatic video telling the story of a typical nursing home patient transferred to the hospital after a clinical event. While everything done medically was correct, it was not what Anna wanted, and she was not in a position to share her thoughts. Anna had no advanced directive – nothing in writing the staff could follow that showed her wishes. The video is available for doctors to view by calling the Anna's Angels hotline at (908) 598-7906. Anna's Angels are nurses and other health care professionals who go to community groups, showing the video and leading discussions on advanced care planning.

Look for more information in coming months on POLST, and consider referring patients to the palliative care program if appropriate.



CPOM

Computerized Physician Order Management (CPOM) is a core component of an Electronic Medical Record (EMR). This completely electronic repository of patient data provides caregivers access to valued patient information and decision support. The federal government, through the American Recovery and Reinvestment Act, established incentives to encourage hospitals and other providers to implement the EMR system for the purposes of safety and improved patient outcomes.

In 2007 we began our CPOM implementation using the McKesson Horizon Expert Order system (HEO) starting with a pilot in pediatrics and rolling out to medical-surgical nursing units. In 2009 and 2010, our residents began using HEO as we expanded its function and use. We rolled out training and support to our hospitalist groups in 2011. Supported by a CPOM user group at Overlook Medical Center, we implemented many significant upgrades and enhancements to the CPOM system to continuously improve the ability of our medical staff to directly input patient care orders into the system.

To further promote CPOM, we will begin a rollout based on nursing unit, where CPOM will be required for placing orders. The first nursing unit to go "paperless" for providing orders is 10CD. This means all physicians caring for patients on 10CD will be placing orders in CPOM.

We will be providing training and refreshers in advance, starting the week of June 11, from 7 am to 7 pm Monday through Friday, and with Saturday morning hours. The trainers will be stationed on 10CD, in medical records, and the physician lounge. In addition, two trainers will roam the floors to support physicians learning to input orders. The trainers will be easily identifiable by an orange button that states, "GO LIVE SUPPORT - Need Help!" They will also wear Atlantic Health badges with no pictures. The trainers have been asked to introduce themselves when they go to a nursing unit.

"Go Live" will be on Tuesday June 26, 2012. Teams of support personnel will be on hand 24/7 for several weeks following, to guide and help you as you learn CPOM and become more comfortable using it.

As always, please feel free to contact a physician support team member at any time by calling (866) 251-4568 for CPOM assistance, training, requests and suggestions.

Thank you for being an essential partner in reaching our quality and safety goals.

ACO UPDATE

A key element of the Patient Protection and Affordable Care Act of 2010 is the creation of Accountable Care Organizations (ACO). An ACO is a group of providers (e.g. hospitals, physicians, and others involved in patient care) that works together to coordinate care for patients with original Medicare. The goal of the ACO is to deliver seamless, high quality care across the continuum of inpatient, post-acute, and outpatient care, the virtue of which is to improve patient outcomes, patient and provider satisfaction, and reduce costs. ACOs can apply to participate in the Medicare Shared Savings Program (MSSP). Atlantic Health formed its own ACO in February, 2011. The Atlantic ACO was approved by CMS for participation in the MSSP as of April 1, 2012.

Some key facts:

Atlantic ACO is divided into 4 regions:

- Morris
- Sussex
- Union/Somerset
- Bergen/Valley Hospital

There are 1,395 physicians and other health care providers as part of the ACO.

There are approximately 47,000 Medicare beneficiaries attributed to the Atlantic ACO, making it the second largest of the 27 currently approved ACOs nationally.

The members of the Union/Somerset board are:
Susan Kaye, MD, Chairman
Samantha Pozner, MD
Jeffrey Feldman, MD
Thomas Jackson, MD
Paul Starker, MD
Norman Luka, MD
Robert Sussman, MD
Mark Holtz, COO
Steven Sheris, MD (alternate)

There are three main board committees:
Performance improvement – Chair, Steven Sheris, MD
Nominating and credentialing – Chair, Thomas Jackson, MD
Analytics and reporting – Samantha Pozner, MD

Many ACO features are designed to support the physician member's ability to address the needs of high-risk patients in the community, which can avert the kind of medical crisis that results in unnecessary hospital admission. The ACO care coordination center, staffed by very experienced and skilled registered nurse navigators, will partner with physicians to address their needs.

If you think your most vulnerable high-risk patients can benefit from the care coordination center resources, you can proactively utilize these services by calling the care coordination center. This center is open Monday through Friday from 8 am to 5 pm, and Saturday 9 am to 3 pm. You can call (855) ACO-7171 or fax (973) 379-8413.

If you have any questions or are interested in serving on any of the board committees, please contact John Rosellini, director, business development & physician relations, Overlook Medical Center, (908) 522-4978 or Mark Holtz, COO, (908) 522-3733.

CASTLE CONNELLY RESULTS

The Castle Connelly Medical, Ltd. results are in. Here's how Overlook Medical Center fared in this year's ratings, for hospitals with more than 350 beds.

#1 – Top Hospital for the Treatment of Strokes
#1 – Top Hospital for the Treatment of Neurological Disorders
#3 – Top Hospital Overall
#3 – Top Hospital for the Treatment of Breast Cancer
#3 – Top Hospital for the Treatment of Prostate Cancer
#3 – Top Hospital for Hip and Knee Repair
#3 – Top Hospital for High Risk Pregnancies
#3 – Top Hospital for the Treatment of Heart Failure
#4 – Top Hospital for the Treatment of Pediatric Cancer
#6 – Top Hospital for the Treatment of Coronary Surgery

In terms of post-discharge patient ratings, here's where Overlook stacked up:

#5 – Patients Highly Satisfied
#8 – Registered Nurses Always Communicated Well

2012 SYMPOSIA

When	What	Where	Contact
Wednesday, September 12, 2012 5:10 pm – 9:20 pm	Updates in Pain Management	Wallace Auditorium, Overlook Medical Center	www.regonline.com/painsymposium2012 For information call: (908) 522-6112
Thursday, September 27, 2012 8 am - 5 pm	13th Annual Neuroscience Nursing Symposium	The Palace at Somerset Park, Somerset, NJ	www.regonline.com/atlanticneuronursing2012
Saturday, October 20, 2012 8:00 am - 1:00 pm	Movement Disorders Symposium	Wallace Auditorium, Overlook Medical Center	Registration information to follow
Saturday, October 27, 2012 7:30 am – 12:00 Noon	Radiology Symposium	Wallace Auditorium, Overlook Medical Center	Registration information to follow For more information call: (908) 522-6287

Overlook Medical Center
ATLANTIC HEALTH SYSTEM

INSIGHTS
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PRIDE

Overlook Medical Center has been widely recognized for the quality of care it provides, the high quality physicians on its medical staff, and nurses, and allied health professionals that work here. However we all believe, based on the feedback we get from patients through the Press Ganey surveys, that we can and must improve the way that patients experience care, and as our mission states, provide this care within a healing culture.

Two months ago, a diverse group of stakeholders from across the Atlantic Health System met to brainstorm what could help us achieve top quartile performance for patient satisfaction. This group included the hospital chief nursing officers, operating directors and trustees. As a result, we are currently piloting our PRIDE Service Promise on 9CD. The purpose of the trial is to work out the process issues and roll out the PRIDE Promise to all areas of OMC in July. The PRIDE Promise is made to patients and their families, and formalizes clearly our expectations of the staff.

The PRIDE Promise is:

P – Professionalism – We will introduce ourselves and share the reason we are here
R – Respect – We will respond sensitively to your individualized needs and concerns
I – Involvement – We will keep you informed and involved in your plan of care
D – Dignity – We will be sensitive to your emotional, physical, spiritual, and cultural needs
E –Excellence – We will provide excellent patient care with every interaction

At the end of the PRIDE Promise we tell patients that if their experience does not meet the promise, that they should tell their bedside nurse or caregiver. If it still does not meet the promise, they should call the nursing station or the hospital operator. We believe that this will give us the opportunity to provide service recovery when the patient's experience does not meet the promise.

One way that everyone can work together to deliver on the promise is to start with Professionalism and introduce ourselves and share the reason we are there during every patient encounter. Achieving top performance in patient satisfaction is teamwork. Let's all deliver on the PRIDE Promise and enhance the healing culture.

NEW PHYSICIANS

Amin, Shilpa, MD
Emergency Medicine

Chiang, Fang-Chin, D.O.
Emergency Medicine

Enriquez, Melissa J., MD
Emergency Medicine

Khan, Mansoor, MD
Emergency Medicine

Milano, Marc A., M.D.
Emergency Medicine

Pritsiolas, Leonidas, MD
Emergency Medicine

Sapira, Andrew, MD
Emergency Medicine

Smith, Corey K., M.D.
Emergency Medicine

Strater, Sharon, MD
Emergency Medicine

Heath, John M., M.D.
Family Medicine

Kowalenko, Thomas A., D.O.
Family Medicine

Nihalani, Shubhamvada, MD
Family Medicine

Baran, David A., M.D.
Medicine/Cardiology

El-Atat, Fadi A., MD
Medicine/Cardiology

Garg, Anshu, M.D.
Medicine/Cardiology

Michael, Hazar, M.D.
Medicine/Gastroenterology

Bielory, Leonard, M.D.
Medicine/Internal Medicine

Chan, Diana G., MD
Medicine/Internal Medicine

Gbadamosi, Sikiru A., M.D.
Medicine/Internal Medicine

Grigaux, Claire N., MD
Medicine/Internal Medicine

Ibikunle, Olumuyiwa, MD
Medicine/Internal Medicine

Kirupaharan, Mythely, M.D.
Medicine/Internal Medicine

Lytle, Carole, MD
Medicine/Internal Medicine

Malhotra, Amit, MD
Medicine/Internal Medicine

Rehman, Muhammad, M.D.
Medicine/Internal Medicine

Salvatore, Paolo A., M.D.
Medicine/Internal Medicine

Torbus, Andrzej P., M.D.
Medicine/Internal Medicine

Garg, Vipin, M.D.
Medicine/Pulmonary Disease

Rehman, Muhammad, M.D.
Medicine/Pulmonary Disease

Wilt, Jessie, MD
Medicine/Pulmonary Disease

Felberg, Robert, MD
Neuroscience/Neurology

Stillerman, Charles B., M.D.
Neuroscience/Neurosurgery

Cherian, Sabina K., M.D.
Obstetrics Gynecology

Jurema, Marcus, MD
Obstetrics Gynecology

Lalwani, Sasmira, M.D.
Obstetrics Gynecology

Kasdaglis, Tania, M.D.
Obstetrics Gynecology/Maternal-Fetal Medicine

Brittman, Jaclyn F., D.O.
Pediatrics/General Pediatrics

Mathew, Seema A., M.D.
Pediatrics/General Pediatrics

Ploshnick, Andrea G., M.D.
Pediatrics/General Pediatrics

Segal, Eric B., MD
Pediatrics/General Pediatrics

Tasneem, Afser, MD
Pediatrics/General Pediatrics

Silver, Eric S., MD
Pediatrics/Pediatric Cardiology

Mehta, Sanjay, D.O.
Pediatrics/Pediatric Emergency Medicine

Perez, Maria E., DO
Pediatrics/Pediatric G astroenterology

Adeola, Yetunde, MD
Psychiatry

Saiz-Quintana, Maria E., MD
Psychiatry

Whang, Phil J., MD
Psychiatry

Yeung, Wilbert D., M.D.
Psychiatry

Bhatti, Waseem A., MD
Radiology

O'Connor, Mary T., M.D.
Radiology

Stewart, John E., MD
Radiology

Camacho, Marc, MD
Radiology/Virtual Radiological Professionals

Sacco, Margaret Mary, MD
Surgery/General Surgery

Purewal, Baljeet, MD
Surgery/Ophthalmology

Stahl, Roslyn M., M.D.
Surgery/Ophthalmology

Wong, Charissa J., MD
Surgery/Ophthalmology

Cerio, Dean R., MD
Surgery/Plastic Surgery

Kutlu, Hakan M., M.D.
Surgery/Plastic Surgery

Loghmanee, Cyrus F., MD
Surgery/Plastic Surgery

Corbin, Richard, D.P.M.
Surgery/Podiatry

Mgbako, Chudi, D.P.M.
Surgery/Podiatry

Sullivan, Brian S., D.P.M.
Surgery/Podiatry

Opell, Brett, M.D.
Surgery/Urology

Sundick, Scott, MD
Surgery/Vascular Surgery