THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | SEPTEMBER 2015

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The Art of Physician Mentoring

Dr. James Hines, Covenant HealthCare Chief of Staff

Mentoring is more then just teaching a student to listen to a heartbeat or to tie a suture in surgery. It is a relationship intended to advise or train someone, especially a younger colleague.

The original "Mentor" is a character in Homer's epic poem, *The Odyssey.* When Ulysses, King of Ithaca went to fight in the Trojan War, he entrusted the care of his kingdom to Mentor. Mentor, a wise man, also served as the teacher and protector of Ulysses' son, Telemachus.

Mentoring is a relational process in which a mentor, who knows or has experienced something, transfers that knowledge to a mentee. This is done at an appropriate time and manner, so that it promotes character, integrity, insight, wisdom and a host of other traits.

The Opportunity

What an opportunity we have as Saginaw physicians to mentor the younger generation of medical students and residents! Central Michigan University third year medical students began their rotations in Saginaw on July 1, and 95 CMU residents are hard at work in their respective residencies.

I have already had the opportunity to work with a number of CMU students in surgery and several have helped me deliver babies. They are smart, eager to learn and they watch every move that I make! You see, they do not yet know what it means to be a physician, how to act and respond, and how to speak with a patient or family.

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Battling Burnout

Dr. Michael Schultz, Vice President of Medical Affairs

"Together, the Medical Staff and Covenant HealthCare are driving extraordinary care and value for our patients and communities."

Hopefully, most of you now recognize the statement above as the shared vision of Covenant HealthCare (the institution) and the Covenant HealthCare Medical Staff. This certainly puts patient safety at the foundation of our aspiration. One of the keys to our success in achieving this vision is quality of life for all healthcare personnel, which means work-life balance. That means having resilience and avoiding burnout.

Burnout Syndrome

Burnout syndrome is comprised of emotional exhaustion, depersonalization and ineffectiveness. According to the American Academy of Family Physicians (AAFP), burnout is not an individual failure, it is a system problem. Much has been written about physician burnout, and it relates to many important aspects of our personal and professional lives.

The adverse impact is huge, including:

- Medical errors
- Lower patient satisfaction
- Lower clinical productivity
- Work hour reduction
- Career change
- Poor clinical outcomes
- Increased malpractice
- Absenteeism
- Early retirement

Various surveys demonstrate that nearly one-half of physicians in the United States meet criteria for burnout. This supports the AAFP's position that burnout is not primarily a result of susceptible individuals, but relates more to the healthcare delivery ecosystem. Imputed contributing factors include dealing with electronic health records, bureaucratic hassle from regulatory and funding agencies, and being held accountable to questionable rules by non-clinical and lesser trained individuals. Add on the lightning speed with which medical knowledge is increasing and the plethora of changing guidelines, and the question arises: **How can one prevent becoming overwhelmed or burned out? Resilience is a potential antidote.**

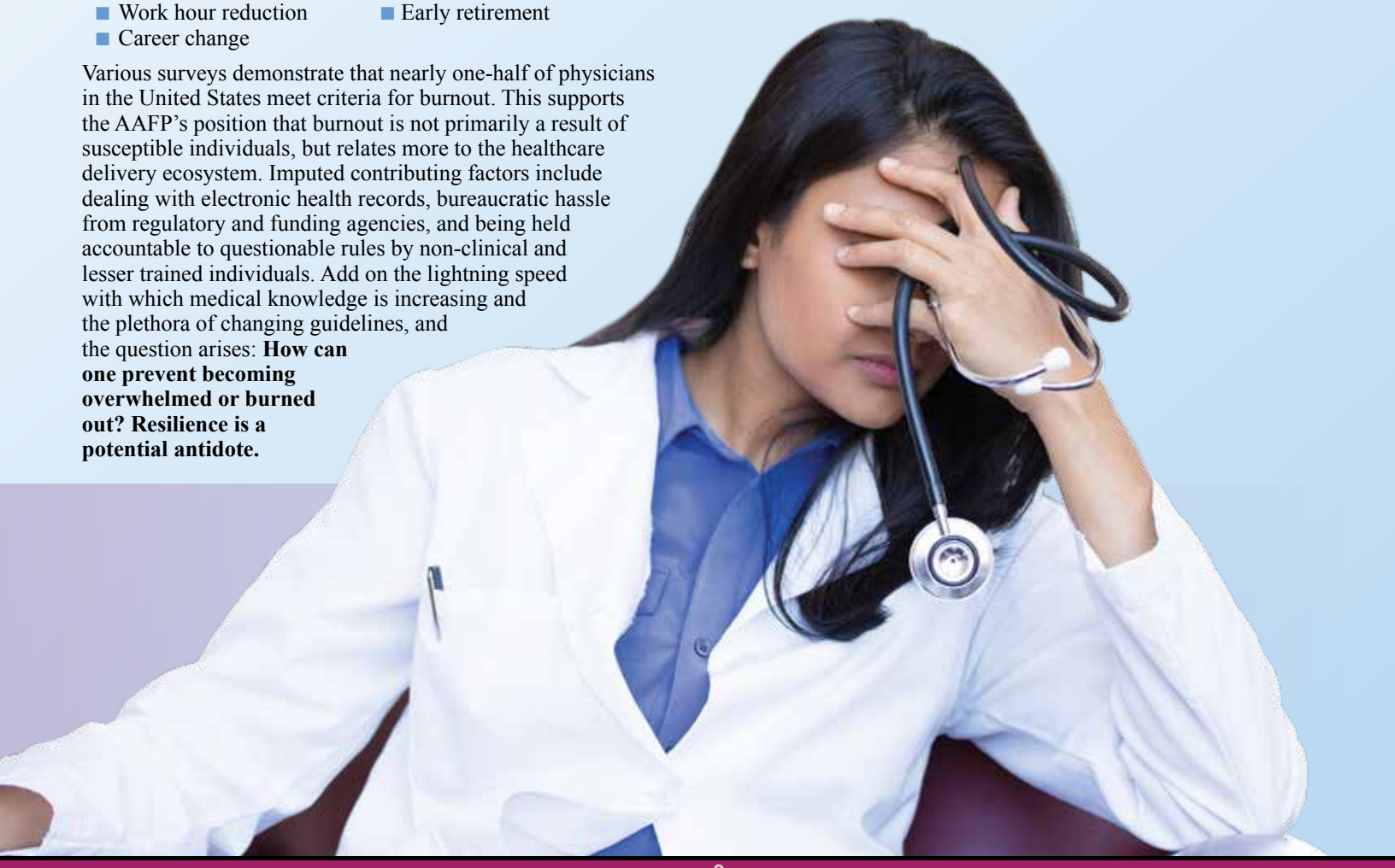
Building Resilience

According to Merriam Webster (2015 Mobile App), resilience is "the ability to become strong, healthy, or successful again after something bad happens; the ability of something to return to its original shape after it has been pulled, stretched, pressed, bent, etc."

Resilience is the relentless ability and commitment to stay the course in the face of adversity. It is a key attribute of High Reliability Organizations. If you are resilient, you can resist complete burnout.

There are many paths to building resilience. Achieving work-life balance is one of the most important paths, and can be achieved by:

- Exercising regularly
- Ensuring dedicated family time
- Using social media or other social outlets
- Learning to say "no"
- Participating in meaningful community activities
- Reading non-medical literature
- Going out for entertainment (movies, concerts, festivals, etc.)



Bite-Sized Resilience

A Free Tool

Visit http://dukepatientsafetycenter.com/ and scroll to the link, "Bite-Sized Resilience: Three Good Things." It will open an 11-minute YouTube video at https://www.youtube.com/watch?v=57ru-P7EuMw/ in which Dr. Sexton describes the tool and how to use it.

Using Empathy

Another tool that can bolster resilience is empathy, which has been linked to improved patient outcomes, better patient satisfaction and lower risk of malpractice suits. However, we must be cautious. Empathy can be categorized as affective and cognitive. With **affective empathy** we are more in tune with the patient's actual feeling, but too much of this can lead to "compassion fatigue," which can contribute to burnout. **Cognitive empathy** is more of an intellectual understanding of the patient's experience, mental state and motivation.

According to experts at Université Paris Descartes and Université de Montréal, "It has been suggested that the optimal empathic approach for physicians should be **'clinical empathy,'** preventing them from reaching a too compassionate or sympathetic position, without ignoring the emotional reaction and feeling of the patients." See the full article at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381244/.

Massachusetts General Hospital offers an online "Empathetics" course for healthcare professionals (with CME) that is designed to improve empathic skill, and appears to combat physician burnout. This course has three modules: 1) Introduction to the Neuroscience of Empathy, 2) Managing Difficult Medical Interactions and 3) Delivering Bad News. Learn more at: http://empathetics.com/products.

Practicing Positive Psychology

Positive psychology is also fundamental to resilience and empathy. To overcome your skepticism, consider this story. At a Michigan Hospital Association workshop on healthcare worker burnout, the instructor from Duke University, Brian Sexton, made some pretty hefty claims about positive psychology and offered a simple, free online tool via their Patient Safety Center (see above). He said that doing the recommended activities for two weeks, about three minutes each night, would enhance happiness, improve work-life balance, improve sleep and reduce burnout. Sexton stated how this activity is more effective than Prozac (and similar drugs) for depression and that it even works for those who are not depressed.

This author followed Sexton's advice and is still enjoying the emotional benefits of using this impressive tool. Try it: perhaps you could have a similar experience.

For more information, contact Dr. Schultz at 989.583.4103 or mschultz@chs-mi.com.

2015 Provider Engagement Survey Results

The Physician/NP/PA Engagement Survey results are in! This year we had a 55% total response rate with over 300 responses, up 1% from 2013. Thank you for your participation, as your feedback helps Covenant HealthCare focus on the things most important to employed and independent providers. We are currently reviewing the survey data and will share detailed results with you in the coming weeks through a variety of communications.

Survey Groups	2015 Response	2013 Response
Covenant-Employed Physicians	84%	87%
Covenant-Employed Advanced Practice Providers (APPs)	78%	66%
Independent Physicians	42%	43%
Independent APPs	30%	28%
Total Responses	**55%**	**54%**

The ADHD-Sleep Connection in Kids

GUEST AUTHOR
Dr. George Zureikat, Covenant HealthCare Sleep Center and Mid-Michigan Sleep Center

Children diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) may be suffering from related sleep disorders, which can further affect their ability to function socially, physically and academically. In addition, a subset of patients thought to have ADHD may actually have a sleep disorder causing ADHD-like symptoms.

Any child needs 10-14 hours of sleep each day to fully function, while teenagers need at least nine. But in the United States, 25% of children experience some sort of sleep disorder. These range from not going to bed early enough to insomnia, delayed sleep phase, sleep apnea, restless leg syndrome (RLS), night terrors, sleep walking and narcolepsy.

Sleep deprivation can result in hyperactivity, inattention, impulsivity, oppositional behavior, moodiness, irritability and difficulty waking up. The consequences (psychiatric comorbidities) are exacerbated in kids with ADHD, who frequently experience sleep disturbances too (see Figure 1). Hyperactivity and restlessness, for example, can cause sleep problems, as can anxiety and behavioral disorders. Medications can also have sleep-deprivation side effects.

In the United States,

25% of children

experience some sort

of sleep disorder.

ADHD-Sleep Studies

Many studies comparing the sleep of ADHD children to control groups have been conducted. Results from the ADHD group reveal:

- The worse the sleep problem, the more severe the ADHD
- Higher bedtime resistance, delayed sleep onset and more awakenings
- Higher sleep disorder breathing (SDB) and daytime sleepiness
- Higher RLS and periodic leg movement during sleep (PLMS)
- Higher related behavioral difficulties
- Lower scores on neurobehavioral testing – to the point of impairment
- Higher parent reports of sleep complaints

Sleep Treatments

The prevalence of ADHD in children in the U.S. is 4-11% with a 3:1 ratio of boys to girls.

Healthcare professionals who diagnose and treat ADHD children should consider the relationship between sleep disorders and ADHD. Clinical interventions should include:

- Screening for etiologic and exacerbating factors
- A sleep study may be indicated to diagnose a potential and treatable sleep disorder
- Behavioral management strategies and good sleep hygiene to address the sleep disorder, both of which improve outcomes and in some cases, eliminate the problem
- Pharmacologic treatment choices that even out the ADHD symptoms without impacting sleep
- Measuring ferritin levels if RLS/PLMS are suspected; children receiving iron supplements show improvement
- Potential light therapy, which also shows improvement

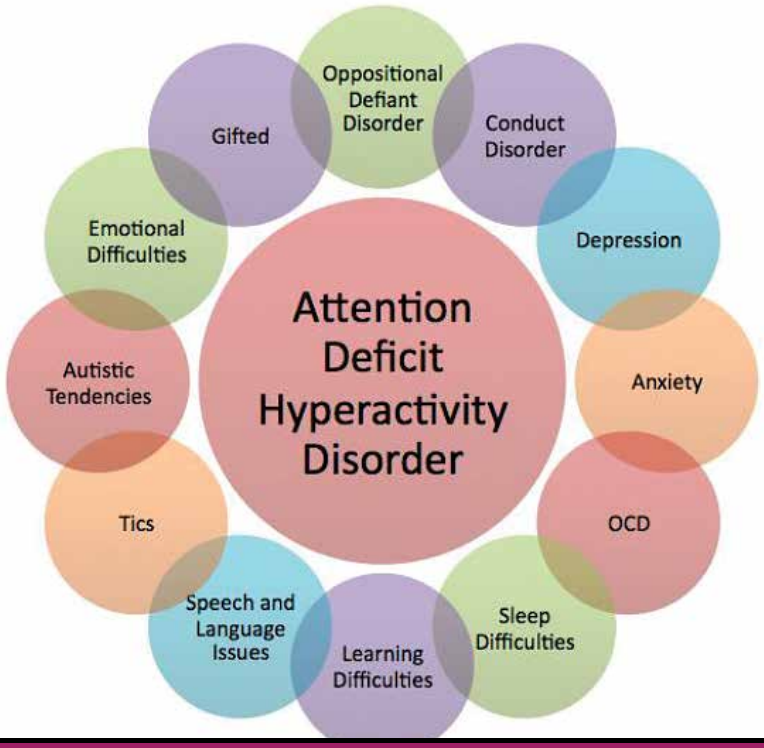
Summary

Sleep problems in ADHD are multifactorial. However, correctly identifying the problem facilitates the appropriate management of sleep disturbances in this population. It is shown to reduce the behavioral symptoms and improve the quality of life for children and their families.

For more information, please contact Dr. Zureikat at zureikat@midmichigansleep.com or 989.583.2930.

FIGURE 1

Psychiatric Comorbidities & Sleep Disturbances



Hysterectomy: Making an Informed Choice

GUEST AUTHOR
Dr. Thomas Minnec, Women's OB-GYN

Hysterectomies are one of the most frequently performed surgical procedures in the United States, with about 433,000 inpatient procedures performed annually. They are performed vaginally with no abdominal incision, abdominally with small incisions using conventional laparoscopic surgery (CLS), or via an open incision in the abdomen. The use of robotic-assisted surgery (RAS) – initially developed for battlefield medicine – is also gaining in popularity. It allows surgeons to perform operations from a computer console, and is a relatively new form of laparoscopic surgery.

Considerations

Choosing the type of hysterectomy and technology should be driven by what is the safest and most cost-effective for the patient. For example, while robotics have a "new-age" appeal, vaginal hysterectomy may be the most prudent choice for the patient, depending on the situation. Consider this:

- In 2009, after extensive study, the American Congress of Obstetricians and Gynecologists (ACOG) said that "vaginal hysterectomy is the safest and most cost-effective method to remove the uterus for noncancerous reasons … is associated with better outcomes and fewer complications than either laparoscopic or abdominal hysterectomy … and quicker recoveries."
- A recently published joint committee opinion from ACOG and the Society of Gynecologic Surgeons (March 2015) reviewed data suggesting that RAS has higher costs but no obvious advantage in regards to morbidity when compared with CLS for benign hysterectomies.
- A Cochrane Review (December 2014) based on six studies found there is only "low-quality" evidence on which to conclude that RAS is as safe as CLS for hysterectomies and only "moderate-quality" evidence that it reduces hospital stays. Note: Cochrane works collaboratively to produce systematic reviews of current medical evidence to answer key medical questions, publishing findings in the Cochrane Library.

The Jury Is Out

Clearly, the jury is out, and more research is underway to better understand the pros and cons of the various techniques. There is no question that robotic technology is critical to the future of medicine, but it should not automatically replace procedures that have stood the test of time. A number of factors need to be considered, including the size and shape of the vagina and uterus, accessibility to the site, surgical experience, the patient's condition and comorbidities, the extent of the disease and hospital support.

Physicians should carefully review all of the surgical options with patients, discussing the risks and benefits of each approach and also explaining that "high-tech" is not always a replacement for "proven outcomes" and evidence-based medicine. This, combined with consultation with objective experts, can help drive a decision that results in the best outcomes for each patient.

For more information, contact Dr. Minnec at 989.652.1460 or tminnec@womesob.com.

Breakthroughs in Hepatitis C Treatment

GUEST AUTHOR
Dr. Muhammad Umar Khan, General Medicine Section Chief and Infectious Disease Physician

We've been hearing a lot of good news in the media lately about breakthrough Hepatitis C Virus (HCV) treatments approved by the Food & Drug Administration (FDA). The new drugs are focused on providing all-oral, higher cure-rate treatment regimens for most people. They are more effective, easier to tolerate and require shorter treatment times than previous regimens such as Interferon and Ribavirin, which are challenging to administer and tolerate. Please review the information below to help you more effectively treat patients who have been suffering from this chronic disease.

Indications for Hepatitis C Treatment

- Diagnosis of liver fibrosis (Metavir F2), advanced liver fibrosis (Metavir F3) or cirrhosis (Metavir F4)
- Liver transplant
- Type 2 or 3 mixed cryoglobulinemia with endogenous damage (e.g., vasculitis)
- Proteinuria nephrotic syndrome or membranoproliferative glomerulonephritis
- HIV co-infection
- Hepatitis B co-infection
- Diabetes mellitus (insulin resistant)

Rx Considerations

Goals of Rx

- Eradicate the HCV virus from the blood stream as evidenced by sustained virological response (SVR)
- Stop progression of fibrosis
- Prevent cirrhosis or liver cancer

Drivers for Rx Decisions

- Hepatitis C genotype
- Presence or absence of cirrhosis
- If cirrhosis compensated versus decompensated
- Whether patient has previously been treated
- If treated, what medications were previously used
- Comorbid conditions, e.g., end-stage kidney disease (ESRF)
- Co-infection of Hepatitis C with Hepatitis A and B, or with HIV
- Other drugs being used by the patient

Hepatitis C Treatment Regimens

In the United States, 4 million patients have known HCV infections. Of those, 75% have HCV genotype 1a and 1b and 10-25% have genotype 2 and 3. Prior to 2011, the medical community was confined to treating patients with Ribavirin (RBV) and Pegylated Interferon (Peg-IFN). Then, in May 2011, VICTRELIS (Boceprevir) and INCIVEK (Telaprevir) were FDA-approved as protease inhibitors and direct-acting antivirals. Used in combination with Peg-IFN and RBV therapy, they have since been replaced by the newer Interferon-free regimens. RBV is still used in combination with newer treatments when necessary.

Table 1 shows a timeline of recent FDA approvals, while Table 2 provides typical treatment regimens.

TABLE 1
RECENT FDA APPROVALS

DATE	FDA-APPROVED TREATMENTS
November 2013	OLYSIO (Simeprevir) is the first once-daily protease inhibitor; it is approved by the FDA for use in combination with SOVALDI.
December 2013	SOVALDI (Sofosbuvir) is a polymerase inhibitor approved for all HCV genotypes that blocks the growth of a specific protein. It is the first FDA-approved drug to include patients who had HIV-HCV co-infection.
October 2014	HARVONI (Ledipasvir/Sofobuvir) is the first combination pill approved by the FDA, and it offers those with genotype 1 an all-oral treatment regimen. It eliminates the need for Interferon injections or Ribavirin.
December 2014	VIEKIRA PAK (Ombitasvir/Paritaprevir/ Ritonavir plus Dasabuvir) is the latest FDA-approved HCV genotype 1 treatment, which can be given with or without Ribavirin. It is approved for HCV-HIV co-infection and people who have had a liver transplant.

Thanks to the dedication of researchers worldwide, people suffering with HCV can benefit from a variety of all-oral treatments that make a once-bleak future much brighter. New treatments continue to emerge, and physicians should consult with experts to choose the best therapy for their patients.

For more information, contact Dr. M. Umar Khan at 989.791.4100 or mukhan1@hotmail.com or any Infectious Disease physician at Covenant HealthCare.

TABLE 2

TYPICAL HCV TREATMENT REGIMENS

MEDICATION	DOSAGE	TYPICAL LENGTH OF THERAPY
HCV Genotype 1a and 1b		
OLYSIO, a protease inhibitor	Simeprevir 150 mg plus SOVALDI (Sofosbuvir). Orally once daily with food.	12 weeks in patients without cirrhosis. 24 weeks in patients with cirrhosis.
HARVONI	Ledipasvir 90 mg / Sofosbuvir 400 mg. Orally once daily with or without food.	12 weeks for naïve patients with or without cirrhosis, and for treatment of experienced patients without cirrhosis. 24 weeks for experienced patients with cirrhosis.
VIEKIRA PAK	Ombitasvir 12.5 mg / Paritaprevir 75 mg / Ritonavir 50 mg. Orally, two tablets once daily in the morning with a meal. Dasabuvir 250 mg tablet. Orally, one tablet in the morning and one in the evening with meals.	12 weeks for genotype 1a, genotype 1b without cirrhosis and genotype 1b with cirrhosis. 24 weeks in genotype 1a with cirrhosis.
For each treatment above, add in Ribavirin	Orally in morning and evening with a meal. Ribavirin dosage is weight-based.	See above.
HCV Genotype 2		
SOVALDI plus Ribavirin	Sofosbuvir 400 mg once daily with or without food. Ribavirin is weight- based, with a dose every 12 hours.	12 weeks for patients without cirrhosis and 16 weeks with patients with cirrhosis.
HCV Genotype 3		
SOVALDI plus Ribavirin	Sofosbuvir 400 mg once daily with or without food. Ribavirin is weight- based, with a dose every 12 hours.	24 weeks for all patients.

A Clear "Fall" To Action

GUEST AUTHORS
Alan Spencer, Covenant HealthCare Medical/Surgical Services Director and
Denise Lipscomb, RN, MSN, CPPS, Falls Process Improvement Team Facilitator, Patient Safety & Quality

When your patient is in the hospital, the last thing you want is complications caused by a fall. Falls, and injuries caused by falls, are a reality for too many patients at medical institutions. Most are unassisted falls in which the patient does not ask for staff assistance and is found on the floor near the bed or in the bathroom. A smaller percentage are assisted falls in which the nursing staff was safely lowering the patient to the floor to minimize injury.

Fall-related injuries can be classified as:

- Minor: a bruise, abrasion or pain
- Moderate: muscle/joint strain and injuries requiring suturing or splinting
- Major: Any type of fracture, internal injuries and injuries requiring surgery, casting, traction and a neuro consult; or death directly caused by the fall.

A "Fall" to Action

Such trends are becoming a "fall" to action in many hospitals across Michigan, including Covenant HealthCare. The multi-disciplinary Falls Process Improvement (PI) Team was formed in October 2014 and consists of members from Nursing, Patient Safety, Pharmacy, Physical Medicine & Rehabilitation (PM&R), eCovenant, a physician and an ad hoc member from Facilities Services. The team started with the biggest issue: unassisted patient falls. It learned that in 73% of our falls, the patient was found on the floor, in the bathroom or fell out of bed. None used the call light for staff assistance. It was decided to implement a "Call Don't Fall" program to decrease unassisted falls.

Pilot Success

The "Call Don't Fall" program was piloted at Cooper 5 East and Cooper 5 Main/North from April through June 2015. It consists of large triangular signs posted on the wall at the foot of the patient's bed and in the bathroom, reminding patients to "Call Don't Fall." These signs are bright and can be easily read by patients. Teach-back is critical to success and our nurses are using it when reviewing the "Call Don't Fall" program with every patient. The Falls PI team also created a "Falls Prevention in the Hospital" brochure for patients and families to help educate them about the fall prevention program. Patients can agree to "Call Don't Fall" by initialing the brochure after the nurse has reviewed it with them.

Patients immediately provided positive feedback about the "Call Don't Fall" signage, and family members appreciated the reminder message for their loved ones. Nursing staff on the pilot units were engaged and excited to participate in such a program.

During the three-month pilot period, 5 East had a 31% decrease in falls and 5 Main/North had an 18% decrease – however, two were assisted falls (see Table 1). If the two assisted falls are removed from the total fall rate, the improvement is a 36% decrease in falls.

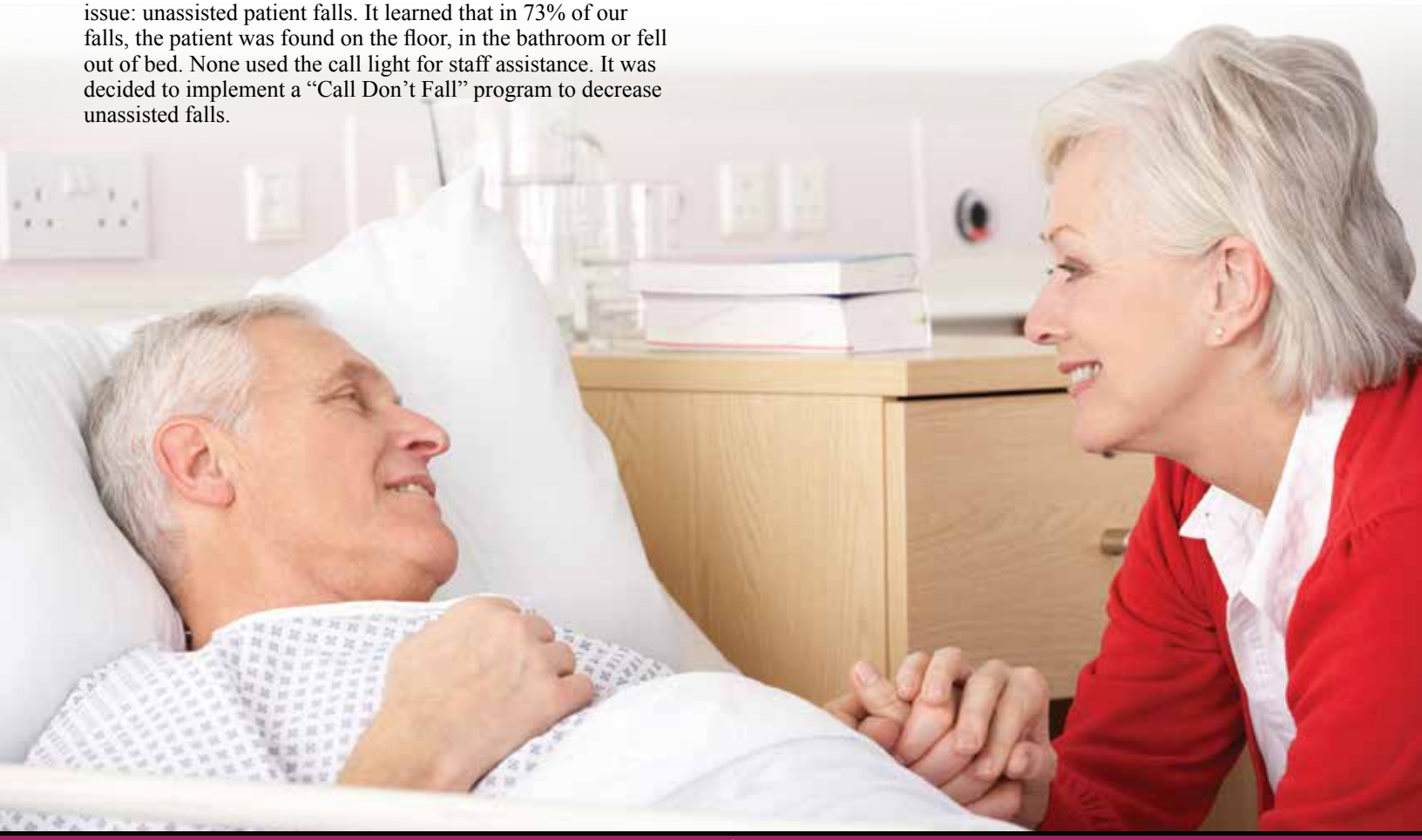


TABLE 1

"CALL DON'T FALL" PILOT RESULTS*

UNIT	FALL RATE PRE-PILOT	FALL RATE POST-PILOT	IMPROVEMENT
5 East	3.86	3.55	31% decrease
5 Main/North	3.84	3.66	18% decrease**

**Cumulative total fall rates per 1,000 patient days*

***36% if the two assisted falls are removed from the total fall rate*

Broad Implementation

Based on those promising results, it was decided to implement "Call Don't Fall" on the inpatient units in the Medical/Surgical, Progressive, Critical Care, Clinical Decision Unit (CDU) and Rehabilitation areas. The Falls PI team continues to monitor fall data for areas of improvement and has also:

- Implemented colored icons on the unit Big Boards to indicate red for High Fall Risk, yellow for Moderate Fall Risk and white for Low Fall Risk to provide a quick visual of the unit population.
- Implemented a Bed Alarm checklist for staff to use for verification of standardized Bed Alarm settings.
- Revised the Falls Risk Reduction Inpatient Policy, Procedure and Guideline to include algorithms with nursing interventions based on fall risk level and a revised post-fall algorithm.
- Eliminated the Hot Feet program, instead utilizing the red slipper socks for High Fall Risk patients.
- Revised the fall improvement report to minimize redundant documentation for nursing staff and implemented a comprehensive post-fall algorithm in the electronic medical record (EMR) for falls documentation that is user friendly.
- Revised the room signage for fall risk patients, and changed the High Risk for Falls banner in the EMR to red.

In Closing

Please help reinforce "Call Don't Fall" with your patients and their families whenever possible. There is an adage that says: "Just when you are tired of repeating a message, is about when it starts to sink in." So don't feel embarrassed to repeat yourselves to patients … it just means that you care!

For more information, contact Denise Lipscomb at 989.583.4099 or dlipscomb@chs-mi.com.

Alert! Dealing with Breast Density

GUEST AUTHOR
Dr. Mark Ludka, Diagnostic Radiology, Advanced Diagnostic Imaging, PC

In the past year, there have been developments regarding mammographic breast density, its significance in the development and detection of breast cancer, and the tools available to augment screening mammography. There continues to be mounting evidence that dense breast tissue not only makes cancer more difficult to detect on mammography, but is also associated with an increased risk of its development. Consequently, the following actions are being taken.

Change to Patient "Results" Letter

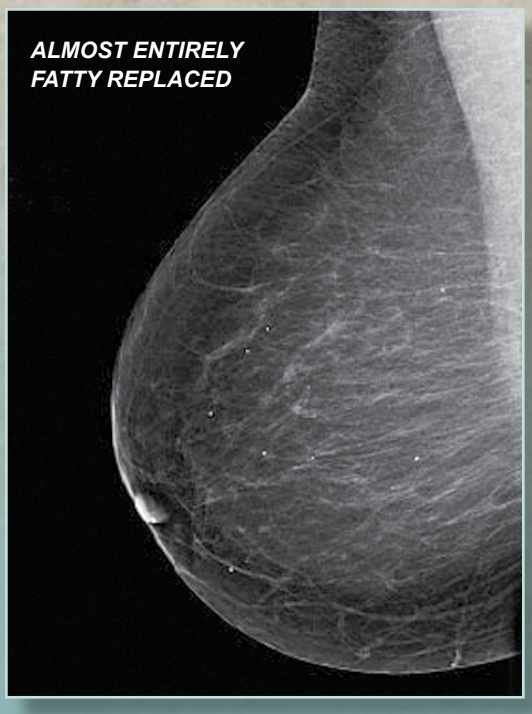
Recently, the Michigan Legislature enacted a law requiring that women found to have dense breasts be notified of this fact as part of the results letter sent to them after the mammogram has been interpreted. As of June 1, 2015, the following paragraph is now included in the letter for women diagnosed with dense breasts:

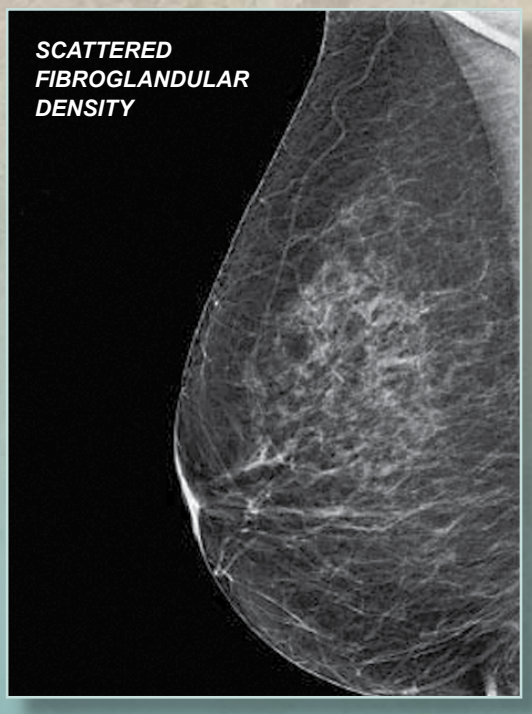
"Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer through a mammogram. Also, dense breast tissue may increase your risk for breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to discuss with your health care provider whether other supplemental tests in addition to your mammogram may be appropriate for you, based on your individual risk. A report of your results was sent to your ordering physician. If you are self-referred, a report of your results was sent to you in addition to this summary."

Eliminating Confusion

Beginning November 2012, all screening mammogram reports from Covenant HealthCare facilities have included a breast density assessment. The following four-level breast density scale was used:

- Level 1: Almost entirely fatty replaced
- Level 2: Scattered fibroglandular density
- Level 3: Heterogeneously dense
- Level 4: Extremely dense





While this numeric scale has been effective in communicating the level of breast density, the American College of Radiology has subsequently recommended that numbers NOT be used in describing breast density because of potential confusion with the final Breast Imaging Reporting and Data System (BI-RADS) assessment, which also uses numbers.

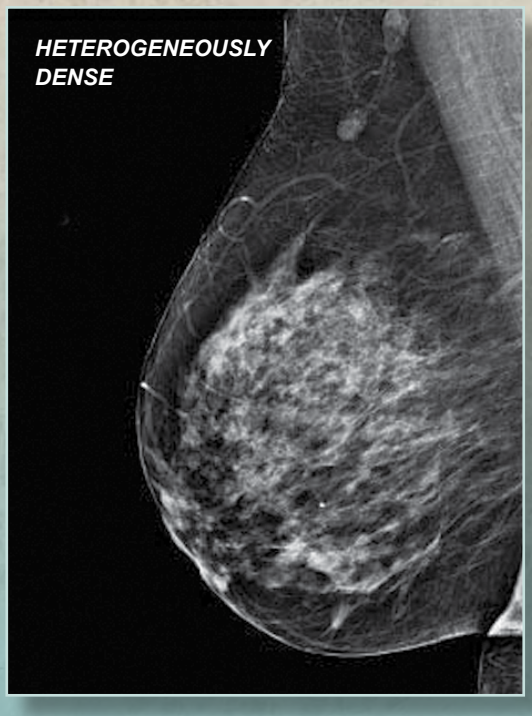
As a result, Covenant HealthCare mammography reports to physicians will no longer include breast density level numbers, but will include the above nomenclature (written description) to describe the level of breast density. Those women having "heterogeneously dense" and "extremely dense" tissue (formally breast density levels 3 and 4) on mammography will also have the aforementioned breast density paragraph included in their notification letter.

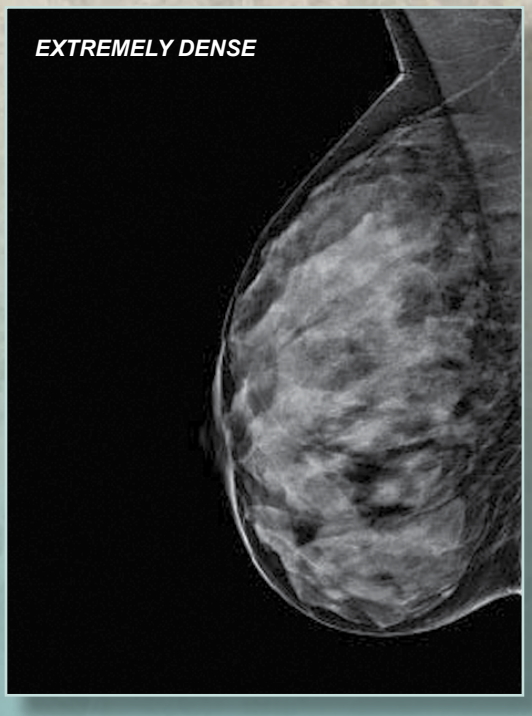
Supplemental Tests Reminder

Available supplemental tests for screening dense-breasted women include MRI and Automated Whole Breast Ultrasound (AWBUS). For those women with dense breasts and a significantly increased risk of cancer (>20% based on risk assessment tools), annual mammography and breast MRI are recommended. For other women with dense breasts, AWBUS can be considered as a supplement to annual screening mammography. Both of these supplemental screening tools are available at Covenant HealthCare.

For more information, contact Dr. Ludka at 989.799.5600 or mludka@adirads.com.

The American College of Radiology has subsequently recommended that numbers NOT be used in describing breast density because of potential confusion with the final Breast Imaging Reporting and Data System (BI-RADS) assessment, which also uses numbers.





ICD-10 Is Truly Almost Here!

Dr. Michael Sullivan, Chief Medical Quality and Informatics Officer

The specter of ICD-10 is almost here. For the past several years, the transition of the U.S. Healthcare system to ICD-10 has been talked about, debated and prepared for throughout the country. At Covenant HealthCare, we are in the final stages of an 18-month process to ensure that we are ready for the transition. Just as Elisabeth Kübler-Ross described the Five Stages of Grief in 1969, we have experienced a similar journey with ICD-10 and hopefully, you are in the "Acceptance" phase. As of October 1, 2015, all healthcare providers and entities will be required to use the ICD-10 code set. As the date looms near, we have been receiving several questions from providers concerning the transition. Below are answers to some of the most frequently asked questions.

Q. ***ICD-10 is just for coders and billers, how is it going to affect me?***

A. It is true that coders and billers will be greatly affected by this transition. But it is important to remember and realize that coders and billers can only use what is documented in the chart to derive the correct codes. Therefore providers will be required to provide the correct information in the chart to support the new codes. Providers will need to be aware of what the new codes are and what they require to provide adequate documentation. ICD-10 is more robust and requires a significant increased amount of patient-specific information. If the documentation is not complete and does not provide the necessary information, the physician will be required to provide the coder with more details. Furthermore, ICD-10 codes will be required when ordering outpatient labs and radiology studies.

Q. ***I can barely remember what day it is. There is no way I can remember 69,000 new codes. What do I really need to know about this ICD-10 thing?***

A. In a nutshell it boils down to specificity. The former ICD-9 code set contained approximately 13,000 codes. ICD-10 has approximately 69,000! In general, you will need to include details such as laterality and ordinality. For specific conditions, requirements will vary; some examples for common conditions in family medicine include:

- Asthma: Intermittent, mild persistent, moderate persistent, severe persistent
- Fractures: Gustilo classification, type of fracture
- Seizures: General or focal, what type, intractability
- Pregnancy: Which trimester
- Poisoning or toxic effect: Which substance
- Ulcers: Which stage

Q. ***How will Epic be affected and what will this mean to me on a daily basis?***

A. The biggest change that will affect providers is the need for more comprehensive documentation. Therefore, most of your documentation will occur in the same fashion in Epic. You may see an increased number of coding queries if your documentation is not sufficient to support the new codes. Epic is being updated with ICD-10 codes, wherever they are used or needed to support coding and billing. Therefore you may see different codes such as charge capture, outpatient test ordering, problem lists and visit diagnosis. Epic has embedded support tools, such as the ICD-10 calculator, to assist you in choosing the correct codes. In the future, you may also see additional support tools embedded in the EMR.

Q. ***What can I do to get ready?***

A. Hopefully you have already begun preparing yourself and your practice.

- First, familiarize yourself with the general concepts behind the code sets and the particular codes that are pertinent to your area and scope of practice. This will allow your documentation to accurately reflect the patient's condition and allow the coders/billers to code accurately. An excellent way to do this is to avail yourself of the ***AHIMA: OptimizeHIT ICD-10 Training Platform*** that was initially made available to all providers in June (see sidebar).
- Update your superbill (if paper), order new CMS HCFA 1500 forms, referral forms, x-ray forms, laboratory forms, authorization forms, and any other forms that use diagnosis codes.
- Ensure that any electronic filing software is compatible with the ICD-10 code transmission.

Q. ***Why are the codes changing?***

A. ICD-10 is a more advanced and robust system than ICD-9, allowing for complex and detailed reporting that better fulfills the needs of healthcare today. The move to ICD-10 will increase the level of specificity available for research, public health and other purposes. The improved clinical detail, better capture of medical technology, up-to-date terminology, and more flexible structure will result in:

- Higher quality information for measuring healthcare service quality, safety and efficiency.
- Improved ability to manage chronic diseases by better capturing patient populations.
- More accurate reflection of patients' clinical complexity and severity of illness.
- Improved ability to identify high-risk patients who require more intensive resources.
- Improved information sharing, which can enhance treatment accuracy and improve care coordination.
- Improved efficiencies and lower costs.
- Greater coding accuracy and specificity.
- Greater achievement of the benefits of electronic health records.
- Recognition of advances in medicine and technology.
- Improved ability to measure outcomes, efficacy and costs of new medical technology.
- Better support of medical necessity of services provided.
- Fewer claims denials.
- Global healthcare data comparability.
- Improved ability to track and respond to public health threats.
- Reduced need for manual review of health records to perform research and data mining, and to adjudicate reimbursement claims.
- Reduced need for supporting documentation to support information reported on claims.
- Reduced opportunities for fraud and improved fraud detection capabilities.
- Development of expanded computer-assisted coding technologies that will facilitate more accurate and efficient coding, and alleviate the coder shortage.
- Space to accommodate future expansion.

Q. ***Remember, it's the government. Is this really going to happen this time?***

A. While the ICD-10 implementation date has been delayed in the past, there is no indication from Congress or elsewhere that another delay will occur this year. In April 2014, the October 2014 implementation date was pushed back one year to October 1, 2015.

Q. ***What happens if I just say "NO"?***

A. ICD-10 is federally mandated. If you do not file claims with ICD-10 codes, your claims will be rejected and you will not be paid. The only exceptions are Worker's Compensation and Auto Liability claims, which may accept either ICD-9 or ICD-10.

For more information about ICD-10 in general, contact Dr. Sullivan at 989.583.7351 or msullivan@chs-mi.com. For help or questions with the OptimizeHIT ICD-10 Training Platform, contact Karla Mishler at 989.583.4186 or kmishler@chs-mi.com, or call the HIM Incomplete Area staff at 989.583.4100.

Get Ready!

Familiarize yourself with the general concepts behind the ICD-10 code sets and the particular codes that are pertinent to your area and scope of practice. **The AHIMA: OptimizeHIT ICD-10 Training Platform is a great place to start.** There are three easy ways to access it:

- ✓ Directly through Epic by clicking on the Links button under the Epic button
- ✓ Directly accessing https://covenantmc.optimizehit.com
- ✓ Install the mobile app, OptimizeHIT, on either Apple IOS or Android devices

For help or questions, see the contact information above.

The Skinny on Fat Grafting

GUEST AUTHOR
Dr. Ronald Barry, Plastic Surgeon

For years, fat grafting to correct scars, repair deformities and improve aesthetics was looked upon with mixed feelings by the medical community due to problems with reabsorption and oily cyst formation. Many felt it was not a reliable, long-term improvement. Recently, however, fat grafting is becoming one of the more common procedures performed in both anesthetic and reconstructive plastic surgery.

Technology Evolution

Using a patient's adipose tissue as a filler material has the advantage of being readily available, natural-feeling and non-immunogenic. Adipose tissue was first transferred in 1893 to correct scars. The earliest report of fat injections to the face and breast to correct contour deformities was in 1909. Because of the problems mentioned above, however, fat grafting to fill large defects fell into disfavor. The advent of liposuction in the 1980s started to turn the tide as the medical community learned more about fat transfer, but continued high reabsorption rates were still a major problem with the procedure.

New innovations in the 1990s changed the way fat grafting was done. Dr. Sidney Coleman "systematized the technique for harvesting, purification and placement of fat to reduce the reabsorption rate," improving long-term results. He popularized the use of fat injections in the face to restore a more youthful appearance as opposed to the standard facelift. Since then the procedure has significantly evolved due to constant advances in research and technology. In the last 5-10 years, fat grafting has become increasingly popular for assistance with management of breast and facial problems.

Two Key Advances

Fat grafting today is considerably different than it was 30-40 years ago in two key ways: the way the fat is harvested and prepared, and more importantly, in the way it is injected.

- **Harvesting:** Aspirating fat from donor sites such as the abdomen and thigh is now done under lower pressures to avoid damaging the fat cells. The fat is prepared for injection by centrifuging for short periods of time, filtrating with saline, or with gravity sedimentation. This allows the fat to be concentrated and the nonessential components to be discarded. Special attention is paid to avoiding exposure of fat to air and bacterial contamination.
- **Injection:** It is now known that fat grafts have a much better chance of "taking" if they are surrounded by a good blood supply, and injected in small volumes. Multiple passes through an area allow the thin strands of fat to have more surface area contact with the surrounding recipient tissue. Ideally, spaghetti-sized strands of fat are injected slowly though smaller cannulas to allow the fat to be surrounded by vascularized tissue, which in turn creates a better environment for the fat to survive, regenerate and become permanent. There is still some degree of resorption, but it is much less than with the techniques of the past. The number of sessions depends on the desired effect.

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Stem Cell Considerations

Over the past decade, researchers have demonstrated that adipose tissue is one of the primary sources of stem cells, also referred to as adipose-derived stem cells (ASCs). Researchers continue to show the value of injecting ASCs into tissue for variety of therapies, including the face and breast. For example, with regard to fat grafting in the radiated breast tissue, several studies show the regenerative effects on the radiated breast tissue after fat grafting. The breast becomes more normal in appearance and texture, and has enhanced vascularity.

A main controversy with this treatment is the potential for tumorigenesis. There are conflicting studies on whether injecting ASCs increases or decreases tumor development. This certainly is a major concern in the United States and probably why fat grafting has been slower to catch on as compared to Europe, where it is more popular. Fortunately, it appears that breast reconstruction patients who have undergone this technique do not appear to be developing recurrent cancers at a higher rate than those who have not had fat grafting. In addition, studies show that the procedure does not affect the accuracy of radiologic breast screening.

Breast Surgery Potential

In breast surgery, among the most exciting uses for fat grafting is the benefit it can bring to augmentations and breast reconstructions – with or without implants. The goal is to improve breast volume, shape, projection, consistency and contour, achieving as natural a look as possible.

In 2007, one of the first examples of regenerative therapies occurred when Dr. Gino Rigotti injected ASCs into a human patient, successfully managing radiation tissue damage with complete *restitutio ad integrum* of the affected tissues – or restoration to their original condition.

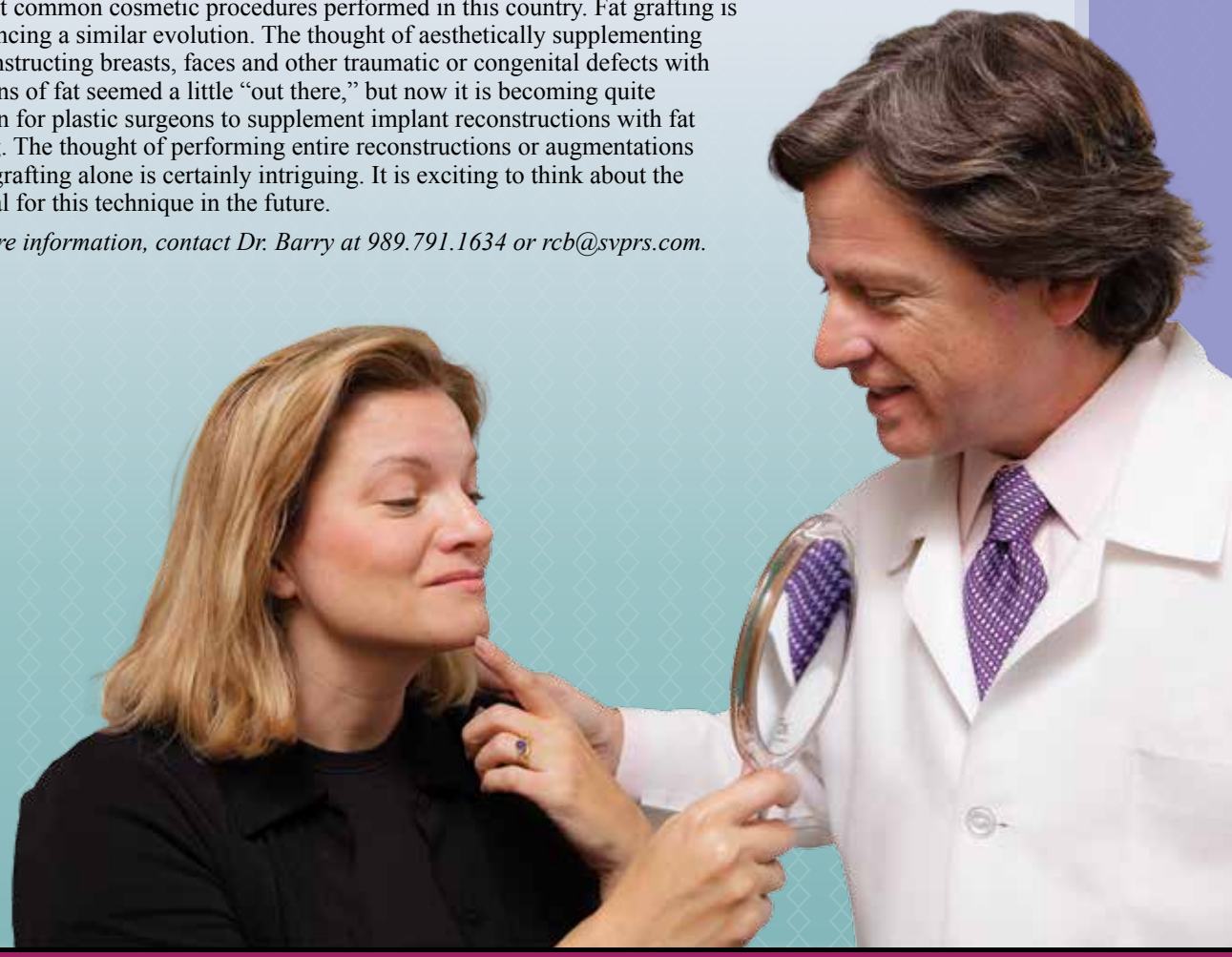
More recently, a BRAVA® external expansion device was introduced to improve grafting success by enlarging the capacity of the tissue site and further enhancing breast vascularity. Results to date look promising, and the device also helps obviate challenges with thin, low-fat patients. A suction device is applied to the breast, enlarging the soft tissue and increasing the blood supply over a period of several weeks. This makes the breast more receptive to the fat grafting and shaping. Multiple procedures are performed over several months to gradually enlarge the breasts to the desired volume.

The BRAVA device does not yet have U.S. FDA approval for augmentations with fat grafting. However, early results with several surgeons in Europe and a few in the Unites States are impressive.

The New "Lipo?"

Liposuction was ridiculed 40 years ago as "too good to be true," but it is now among the most common cosmetic procedures performed in this country. Fat grafting is experiencing a similar evolution. The thought of aesthetically supplementing or reconstructing breasts, faces and other traumatic or congenital defects with injections of fat seemed a little "out there," but now it is becoming quite common for plastic surgeons to supplement implant reconstructions with fat grafting. The thought of performing entire reconstructions or augmentations via fat grafting alone is certainly intriguing. It is exciting to think about the potential for this technique in the future.

For more information, contact Dr. Barry at 989.791.1634 or rcb@svprs.com.



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The Art of Physician Mentoring continued from page 1

We have a challenge before us as experienced doctors to model and teach our profession. How do you tell someone that they have cancer? How does one incorporate cultural differences in making a diagnosis and then in the treatment plan? What does it mean to be part of a care team with a nurse, physical therapist and dietitian? How can we properly interact with colleagues with whom we may disagree? What does it mean to "do no harm?" These are just a few questions that students need to learn how to answer.

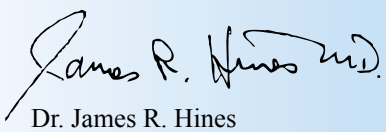
Personal Tips

Below are a few personal tips on beginning the mentoring process:

1. Determine that you want to have an impact in the lives of medical students and residents.
2. Take a student/resident with you to speak with a family postoperatively or to a family conference.
3. Take a student or resident to lunch; talk about cases and life in general.
4. Make rounds with students and residents; demonstrate good bedside care.
5. Ask awesome questions – lots of them!
6. Be a role model: "Do as I do, not just what I say."
7. Be vulnerable; you are not perfect and will make mistakes. Share your mistakes and lessons learned.
8. Bring a student or resident as a guest to a Saginaw County Medical Society meeting, to learn and to interact with your circle of friends and colleagues.

Physicians are, by design, teachers, and are at their best in a mentoring role. Please join me as we mentor the next generation of physicians – who will be taking care of us some day!

Best Regards,



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