THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | JANUARY 2015

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Entering the Next Era of Healthcare

Ed Bruff
Chief Executive Officer

Dear Colleagues:

I am honored and humbled to be named the next CEO of Covenant HealthCare. Spence has left a great legacy, and I'm excited to lead this highly respected and talented institution into the next era of extraordinary care.

Thanks to all of you, we have a strong foundation on which to build, punctuated by many fine accomplishments. These include driving the adoption of a High Reliability culture, creating an excellent independent Covenant-loyal medical staff, building a strong Covenant Medical Group, achieving Trauma Level II accreditation and implementing Epic – while never losing sight of safety, quality and efficiency.

We've also witnessed amazing advances in technologies that make our institution great – such as minimally invasive da Vinci surgery, low-dose radiation for imaging exams, transcatheter aortic valve replacement (TAVR) and leading edge cancer treatments. Additionally, we initiated a promising partnership with the CMU College of Medicine along with many initiatives to create a caring, united culture – one in which we are all proud to work.

The list of achievements goes on, and you can expect to see more as we seek to further improve our sustainability in today's challenging healthcare environment. The creation of two Executive Vice President positions – one for the Physician Enterprise (led by Dr. John Kosanovich) and one for Operations (led by Dan George) – will help build stronger physician relationships and alignment so critical to our future success. The creation of a shared vision for the Covenant HealthCare medical staff and administration, which Dr. Sara Rivette discusses in her article on page 2, reflects continued strengthening of the alignment between our two groups.

Working with you, my goals include 1) ensuring that Covenant HealthCare is second to none with respect to quality of care, patient safety and physician and employee engagement, and 2) maintaining the continued financial stability of this organization.

I am confident that we have the team it takes to succeed – one that is extremely talented and committed to providing the extraordinary care and leadership our community deserves, and one that is dedicated to exceeding – not just meeting – expectations for excellence.

Sincerely,

Edward Bruff

Ed Bruff

New Leadership, New Shared Vision
Partnering for Success

Dr. Sara Rivette, Covenant HealthCare former Chief of Staff

Dear Colleagues:

Recently, we've experienced some exciting leadership changes. As you know, Ed Bruff is now CEO of Covenant HealthCare and we are inspired by his leadership. In addition, my rotation as Chief of Staff is complete and Dr. Jim Hines of the Valley Ob-Gyn Clinic is now in that role. I'd like to say "thank you" to all of you who have supported me, and I know you will provide the same support for Jim who brings unique perspectives and experience to the table.

The focus of this letter, however, is to provide you with an update on a new shared vision for the Covenant HealthCare medical staff and healthcare system. This effort began last year, when the Medical Executive Committee (MEC) identified a set of priorities to pursue over the next few years.

One priority was to create a shared vision for the two groups that reinforces the need for physicians and the institution to partner for success so that together, we can thrive in today's radically changing healthcare environment.

Vision Development

Eleven MEC members from the medical staff and health system volunteered for the Vision Task Team. This diverse team (see sidebar) met on a regular basis to have a meaningful dialogue and create a simple but compelling joint vision for the future.

I'm happy to report that we rolled out the following vision last October to the MEC for their initial input: "Together, the Medical Staff and Covenant HealthCare are driving the future of extraordinary care and best value for our patients and communities."

This new vision:

- Provides a picture of what we all aspire to be when we work together at our best – our "true north" so to speak.
- Unites the medical staff with Covenant HealthCare, so that together, we can focus on all the right things and achieve more than we can alone.
- Will help guide decisions that impact physicians and the health system.
- Complements the overall vision and mission for Covenant HealthCare, which is to provide extraordinary care for every generation.

Vision Ideals

Embedded in the vision are three ideals of equal importance:

- Together: Working together means a partnership in achieving the vision, with mutual trust in each other, striving to achieve alignment of our goals and objectives, accountability to follow through on our decisions, timely communication amongst all parties, and effective input and involvement of each other.
- Leadership: This means driving the future, setting and holding to the highest standards of care, and continually keeping our patients' interests at the center of our work together. Leadership also means driving results, not just dealing with changes in the healthcare environment, but being proactive and leading the way in the activities and decisions that will result in us becoming successful and thriving.
- Extraordinary Care: We absolutely must provide care that is the safest and most reliable care possible, while being the most accessible and responsive too. Extraordinary care means care of the best and greatest value (high quality/low cost), holding patients at the center of care, and providing service that heightens the confidence of the communities we serve.

Your Feedback

We appreciate your input on this shared vision too. If you haven't provided it already in various department and section meetings, feel free to contact any of the members of the Vision Task Team this month with your thoughts and questions. Next month, we'll be asking the MEC to formally finalize and endorse the vision as our direction for the future. This will drive additional work, including new joint agreements on expectations for physicians and the health system, and discussions on how to achieve the vision and define our future.

It was a pleasure serving you as Chief of Staff, and thank you again for your support.

Sincerely,

Sara L Rivette MD

Dr. Sara Rivette, former Chief of Staff

COVENANT HealthCare

Extraordinary care for every generation.

Medical Executive Committee
Vision Task Team

- Ed Bruff
- Dr. Hines
- Dr. Khetarpal
- Dr. Marteja
- Gene Pickelman
- Dr. Rivettte
- Dr. Schultz
- Dr. Sullivan
- Al VanArsdal
- Dr. Wolohan

Covenant Medical Staff *Vision*

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

Three Reinforcing Ideals

Together
Working as Partners

Leadership
Driving the Future

Extraordinary Care
Providing Best Value

Open-Ended Feedback Comments
Part 2: Leadership Responses

Dr. Michael Schultz, Vice President of Medical Affairs

In the last issue of *The Covenant Chart*, we pledged responses to the open-ended feedback comments in the physician engagement survey. We've addressed these comments below, which are grouped under key topics and addressed by the relevant leaders, including myself.

NOTE: Feedback comments appear in blue and represent a combination of remarks; leadership's responses appear in italic.

Nursing Staff

CAROL STOLL
Vice President Patient Services, Chief Nursing Officer

How are we addressing cuts in nursing staff, retention problems and the exodus of very qualified nurses? We need to improve this situation, including morale and training, so that we can sustain our reputation for high quality nurses and patient care.

Let me speak broadly about a few issues expressed by our medical staff about staffing and nursing turnover. Nursing turnover is an area of strategic importance to Covenant HealthCare, the Nursing Leadership Team and Human Resources. Overall, we have a very good story to tell. Turnover is monitored by unit as well as a roll-up to enable national benchmarking. Last fiscal year, Covenant HealthCare targeted a 9.3% RN turnover rate compared to the actual national rate of 14%. We exceeded our target, with an actual turnover of 9%. Similarly, RN vacancy rates of 10% and greater are reported nationally by similarly sized organizations, yet we experienced a much lower vacancy rate of 3%, and less than 1% for bedside RNs.

We recognize that the loss of tenured, expert RNs has a significant impact on the medical staff. Covenant HealthCare, like other organizations, has benefited from RNs extending their working careers during challenging economic times. As the economy has improved, we have experienced an increase in retirements as well as RNs seeking positions that are part-time, less hours per day and do not require holiday and weekend obligations.

Replacing these experienced RNs with new graduates is often heard as a concern. A number of approaches have been implemented to minimize the impact to our patients, quality of care and the medical staff. Orientation of new graduates, for example, is tailored to the acuity of the patient care setting. Experienced mentors are recruited and trained on how to maximize the learning during the orientation period for all new hires. We have been very successful with a Graduate Nurse residency program that provides learning opportunities in a variety of settings during the first year of employment. The unit-based and division educators follow new hires to ensure they are progressing along an expected path for each clinical setting. In addition, the REACH Team and Shift Administrators are very supportive during day and night shifts as valuable resources and coaches for difficult patient or clinical situations.

Note that Nursing Care Assistants (NCAs) are an integral member of our care delivery teams. Covenant HealthCare, like many hospitals in the country, is facing the challenge of increased patient acuity, a rise in the utilization of patient sitters for the confused or suicidal patients, and recruiting skilled NCAs into the rapid pace of an acute care setting. We have taken several steps to ensure that we have a ready pool of NCAs to assist with patient care, including streamlining our NCA screening, interviewing and onboarding process.

An employee engagement survey is also implemented every 12-18 months that is very similar to the survey completed by the medical staff. We receive valuable feedback from the nursing staff about their perception of leadership, working conditions, teamwork within their department, staffing, access to resources to support their work, pay, benefits and many other subjects. The Nursing Leadership Team engages the staff in dialogue to better understand their concerns, identifying and implementing corrective action steps. The feedback from staff who participate in this process is very favorable and we are seeing a positive trend that reflects an increase in engaged and content nursing staff.

If you have specific concerns or questions, we encourage the medical staff to seek out the Patient Services directors, managers or myself.

Hospital Medicine

DR. IRIS MARTEJA
Medical Director, Hospital Medicine

We are concerned that Hospital Medicine accepts patients from community hospitals without obtaining the consent or advice of the specialists. We would also like to suggest that hospitalists provide occasional coverage for community physicians when they are on vacation.

Patient transfers from critical access hospitals are routed via ECC One-Call and handled by the Emergency Care Center (ECC) physicians. The ECC makes decisions about accepting transfers based on the hospital's ability to provide patients with a higher level of service and care, without violating the Emergency Medical Treatment and Labor Act (EMTALA). This federal law obligates hospitals with specialized capability to accept transfers from hospitals that lack the capability to treat unstable emergency medical conditions.

After the patient's arrival at ECC, Hospital Medicine is then informed of the case. Once a hand-off is given by the ECC, Hospital Medicine makes every effort to coordinate care of the patient, which often includes consulting the appropriate specialty service.

Regarding vacation coverage, Hospital Medicine carefully considers independent physician coverage based on staff availability and census.

Epic Electronic Medical Records

DR. MICHAEL SULLIVAN
Chief Medical Quality and Informatics Officer

While we see the value of Epic, it takes time away from patients and other responsibilities, and our productivity is compromised by the overwhelming time consumption. We need to reduce the burden of electronic medical records (EMR) data entry and information overload, and improve support. We also need to encourage more affiliated physicians to use Epic for consistency and patient care improvement.

*The EMR is central to our daily work in caring for our patients. To improve the system, we are engaged in several activities. First, we are continuously striving to make the system more efficient and productive in our daily workflows. Second, we are constantly evaluating how best to incorporate clinical decision support to enhance and ensure that the care we are providing is the most up-to-date, relevant and evidence-based as possible. Third, we continue to evaluate additional Health Information Technology (HIT) products to further enhance the usability and interoperability of the EMR. And lastly, we are focused on streamlining and optimizing the training, support, and communication of enhancements, new features and upgrades to the EMR. Examples include the upcoming adoption of M*Modal, the Epic Stars program, and expansion of Physician Fridays.*

Through the Covenant Physician HIT (CPHIT) committee and physicians, we continue to optimize EMR and related clinical HIT products. We encourage participation in these processes and welcome your input. Please contact me at any time with questions and comments, or if you would like to get more involved.

Work Culture

DR. JOHN KOSANOVICH

Executive Vice President, Physician Enterprise

It's nice that Covenant wants to improve patient care, safety and our work culture, but we need to walk the walk. Management also needs to do a better job about making offices feel like a part of Covenant HealthCare.

The first step in any kind of cultural change is to identify opportunities for improvement, which is why surveys are so important. Then, we can evaluate and take the appropriate action. For example, over the past few years, we initiated the High Reliability Organization to improve patient care, the Disruptive Practitioner Policy to minimize disruptive behavior (see Dr. Schultz's comments), and many other initiatives such as Epic (see Dr. Sullivan's comments).

CMG leadership has started to distribute CMG-wide emails containing strategic and informational updates to keep physicians informed, while the Network Operating Committee is yet another channel for feedback. Meanwhile, we also will be addressing CMG-related feedback via CMG physician channels.

Continued on page 6

Open-Ended Feedback Comments continued from page 5

Disruptive Behavior

DR. MICHAEL SCHULTZ
Vice President of Medical Affairs

Disruptive behavior appears to still be tolerated; I have seen instances of physicians, nurses and management being rude and mean, and who do not promote patient care or respect others. What are we doing about that?

We've implemented the new Disruptive Practitioner Policy for practitioners and allied health professionals to support our ongoing efforts in the elimination of disruptive behavior. Additionally, we are taking a multifaceted approach to raise awareness.

Just like variations in clinical practice patterns, healthcare personnel (whether physicians, nurses, administrators or others) exhibit variations in professional behavior too. Some of the variation in behavior is unwarranted and demands attention. Unfortunately, we have labeled such unwanted variation in behavior as "disruptive." While it may indeed disrupt others' ability to provide the highest quality of care that is safe, the word "disruptive" is itself pejorative and may not be conducive to understanding and addressing such underlying issues as healthcare worker burnout. With that understanding comes knowledge that can be used constructively to address needs such as life-work balance. Currently these needs are dealt with individually, but as more healthcare personnel gain that understanding, and then begin to participate in cultural change efforts, the impact will accelerate. Such efforts are currently underway with the Physician Safety Leadership Team.

Operating Room (OR)

TIM WENZEL
Vice President, Clinical Services

What can we do to improve the pre-op process? To reduce patient anxiety, we need to arrange for outpatient, preoperative anesthesia consultations for select patients planning elective surgical procedures. We should also improve scheduling after hours for add-on cases in the OR to avoid patient waits due to reduced staffing after 3 pm. Plus, it is important to improve the ability to take emergency cases to the OR with appropriate staffing so patients don't get referred to other hospitals.

The Preoperative Assessment Testing (PAT) process allows for a surgeon to schedule a pre-op consult with Anesthesia at the Cooper Treatment Room Area. The surgeon simply requests a consult and the PAT group will arrange a scheduled time with Anesthesia and the patient.

As for reduced staffing at certain shifts or times of the day, this is a result of managing the schedule of staff and the number of cases performed during certain hours of the day. The OR routinely monitors the number of cases by hour of day and staffing is adjusted based on cases – keeping in mind fiscal responsibility, as well as the desire to meet the needs of the surgeon. As we continue to offer a swing room – and to drive efficiencies in the OR to improve turnover, utilize rooms more effectively and improve on-time starts – we will continue to provide staff to meet the needs of the surgeons.

Furthermore, we are currently reviewing and evaluating an opportunity to add staff for nursing, technicians, anesthesia and radiology to support the request by surgeons to provide additional hours of operation for add-on cases. There is also a team of surgery personnel and physicians reviewing and modifying the OR guidelines to support the needs of physicians to assure timely completion of cases and quality of care.

For more information about any of the leadership responses in this article, contact Dr. Schultz at 989.583.4103 or mschultz@chs-mi.com.

Clinical Documentation
The Light at the End of the Tunnel

GUEST AUTHOR
Dr. Glenn Cipullo, Medical Director of Clinical Utilization

This is the first in a series of articles designed to help improve the efficiency and effectiveness of clinical documentation.

Clinical documentation has been and always will be at the forefront of medical necessity for patient care, which is why it is important to stay on top of documentation goals, requirements and time-saving approaches.

Create a Medical Picture

Good clinical documentation provides a medical picture of the patient. It is used in many ways, from diagnosing a patient's condition and identifying comorbid conditions, to establishing the severity of illness and risk of mortality, and identifying a treatment plan.

The goal of documentation is to produce an accurate and complete reflection of the clinical complexity of the patient. It is the foundation for determining the need for acute hospitalization and related services.

Consider the Complexities

Documentation may occasionally appear to be a simple process, but it is not. It involves a complex and thorough understanding of anatomy, physiology, patho-physiology, pharmacy and standards of care in both inpatient and outpatient settings. These elements, coupled with experience, are core to the art of medicine and the successful treatment of our patients.

Remember the Details

One problem that physicians and advanced practice providers face, however, is incomplete documentation. We are used to communicating briefly and quickly with our peers, without a lot of detail. This is because we all have similar skill sets and thought processes, and usually don't require further explanation. Unfortunately, a clinical conversation with colleagues does not equate to adequate documentation for third party payers and reporting agencies. For this group, we must remember the details.

Utilize Documentation and the 5Ws

Fortunately, there are solutions designed to overcome this problem. Start by remembering to utilize documentation from all licensed providers that include ED notes, surgical notes, history and physical exams, progress notes, discharge summaries and consultant's notes. These records should explain the medical story and the thought processes behind treatment plans involving hospitalization, testing, procedures and more.

In addition, follow the "5Ws for Documentation and Auditing" which is outlined in the sidebar. You will fulfill most requirements by making sure your documentation answers questions about what are we treating, where and why treatment is needed, how we are treating it, and when you think the patient will get better.

More Tips

In the next few issues of *The Covenant Chart*, we will perform a deeper dive into clinical documentation, and explore how to record classical documentation that complies with third-party and reporting agency coding requirements for accuracy and recognition.

For more information, contact Dr. Cipullo at 989.583.7002 or gcipullo@chs-mi.com.

The 5Ws for Documentation and Auditing

1 WHAT ARE WE TREATING?
- Diagnosis
- Procedure (if relevant)

2 WHERE IS TREATMENT NEEDED?
- Inpatient
- Outpatient
  - Observation
  - Surgery

3 WHY IS TREATMENT NEEDED?
- Why the diagnosis acutely requires attention
- Relationship to chronicity
- References to requiring testing, drugs or other interventions
- References in variation from baseline to current state
- Potential for adverse outcome

4 WHAT ARE WE DOING TO TREAT?
- What are we actively doing to achieve the recommended level of care
- Implications if not performed

5 WHEN DO YOU THINK THEY'LL GET BETTER?
- Expectation for stay
- Plan for discharge

How Open Access Endoscopy Can Increase Colorectal Cancer Screenings

GUEST AUTHOR
Dr. Mark Pankonin, Gastroenterologist, Covenant Digestive Care Center

The increasing demand for gastroenterology services, especially for colonoscopies, has led to the growing popularity of open access (OA) endoscopy scheduling. This is proving to help gastroenterology practices improve efficiency and capacity while making it easier for patients to schedule appointments for important procedures such as colorectal cancer (CRC) screening.

Historically, obstacles to CRC screening have included lack of public awareness, poor patient acceptance and restricted access due to socio-economic factors, in addition to the capacity constraints of the gastroenterology practice. Each of these systemic barriers have unique and complex challenges that must be addressed using a multi-faceted approach.

For their part, gastroenterologists are working to improve the efficiency, availability and timely supply of their services by implementing models such as the OA endoscopy system.

Benefits of Open Access

The OA system of CRC screening is designed for a specific subset of patients who do not need additional diagnostic workup prior to the procedure. It offers many benefits to these patients and to providers alike. OA, for example:

- Allows qualified patients to directly schedule their appointment for a colonoscopy without an initial pre-procedure office visit with the gastroenterologist. This saves time and money for both patients and caregivers through fewer appointments and less time off work.
- Enables practices to improve efficiency and capacity by eliminating redundancy and reducing the number of unnecessary office visits. They can also enhance patient satisfaction by improving the patient experience.
- Improves the likelihood of increasing compliance rates for recommended screenings over time by eliminating "wasted time" – a common source of frustration.

How It Works

Many hospitals are implementing OA systems, including Covenant HealthCare. With the guidance of a primary care provider (PCP), patients can call a designated number to schedule a colonoscopy.

Occasionally, patients call autonomously through word of mouth or public outreach programs. In this scenario, the patient's PCP will be contacted for authorization, which ensures they are kept in the loop for their patient's care. If the patient does not have a PCP, they will be assigned one from the Covenant HealthCare database of PCPs for an initial office visit in the future.

Safeguards

Appropriate patient selection is facilitated by a qualified nurse using a systematic process and a gastroenterologist-designed questionnaire. Patients are screened for various red flags which would trigger an office visit prior to a colonoscopy. Examples of red flags include lower GI symptoms such as rectal bleeding or diarrhea, history of inflammatory bowel disease, age greater than 75 and active anticoagulation. Any upper GI symptoms discovered by the nurse are not scheduled for an esophagogastroduodenoscopy (EGD) or a gastroenterology visit, but instead directed back to the patient's PCP for additional workup and subsequent referral to gastroenterology if deemed appropriate.

With these safeguards in place, an OA endoscopy system can serve as one small part of a multi-directed initiative to address the systemic barriers preventing universal access to a highly effective CRC screening program.

For more information, contact Dr. Pankonin at 989.583.7537 or mpankonin@chs-mi.com.

Reducing CRC Mortality

Colorectal cancer (CRC) is responsible for approximately 50,000 deaths every year in the United States. This represents 9% of all cancer-related fatalities and is second only to lung cancer. These statistics are particularly lamentable, since death from CRC is preventable if pre-malignant adenomas and early localized CRCs are detected and removed immediately.

Early detection of adenomatous polyps is possible using various screening modalities endorsed by Multi-Society Task Force guidelines, including annual fecal occult blood test (FOBT) or fecal immunochemical test (FIT), flexible sigmoidoscopy every five years, and colonoscopy every 10 years. Colonoscopy has become the preferred modality in recent years due to its superior sensitivity, ability to visualize the right colon, and capacity to identify and remove pre-cancerous adenomas during the same procedure. Although each technique has its strengths and weaknesses, all have been proven to cost-effectively decrease the incidence and mortality of CRC in observational and randomized trials.

Thanks in part to the increased utilization of such screening measures, CRC incidence has declined approximately 2-3% per year over the last 15 years. Despite this encouraging trend, however, CRC screening is still underutilized. According to one estimate, 28% of adults in 2012 aged 50-75 years in the United States had never been screened.

Making CRC screening easier through systems such as OA endoscopy take the "hassle" out of scheduling appointments, remove patient excuses to delay, and save lives in the process.

OPEN ACCESS ENDOSCOPY SCHEDULING: COLONOSCOPY

PATH 1	PATH 2
Call designated number	Call designated number
Pre-screening questionnaire	Pre-screening questionnaire
No diagnostic workup needed	Diagnostic workup is needed
Colonoscopy scheduled	Pre-procedure visit with gastroenterologist
	If there are other GI symptoms, refer back to PCP, but colonoscopy still scheduled.
	Colonoscopy scheduled

MARCH IS

National Colon Awareness Month

Please make a special effort to educate patients and encourage those who meet screening criteria to get their colonoscopy. Remind them about the convenience of open access endoscopy scheduling.

Transcatheter Aortic Valve Replacement
A New Tool for Treating Heart Disease

GUEST AUTHOR
Dr. Safwan Kassas, Cardiologist, Michigan Cardiovascular Institute

As human beings who treat other human beings, we've all had patients at one time or another with symptoms of being constantly short of breath or having chest pain. In some cases, we diagnose the patient with severe aortic valve stenosis.

Sometimes the answer to this struggling patient, and their watchful yet helpless family, is easy: arrange for open heart surgery and a new valve.

Other times, however, the answer is not so easy because the patient is either too old or has so many other illnesses that no one – the physician, patient or family – feels certain that open heart surgery is the ideal answer.

Today, we have a new tool for high-risk patients that allows us to give them a new valve without subjecting them to the inherent risk of open heart surgery. It is called the transcatheter-based aortic valve replacement (TAVR) procedure, and it is now in the arsenal of treatments for aortic valve stenosis patients at Covenant HealthCare.

What Is TAVR?

Just in case you are not familiar with TAVR, it is also called TAVI or transcatheter aortic valve implantation. It is a minimally invasive technology for treating aortic stenosis that avoids the need for an open heart sternotomy. A bioprosthetic valve is inserted percutaneously using a catheter inserted in the femoral artery in the groin. It is implanted or "wedged" into the space within the native aortic valve without removing the old, damaged valve. The procedure is performed in the catheterization laboratory.

Currently, TAVR is reserved for high-risk patients, as mentioned. As with any procedure, it is not without risks, but it does indeed provide these patients with a better quality of life, along with a faster recovery and shorter hospital stay.

How Do Patients Fare?

One might ask: "How do patients fare after the procedure?"

According to the landmark "partner trial," there is significant improvement in survival over conservative medical therapy, and equal survival to surgical valve replacement. Better yet, in a more recent high-risk study of the CoreValve U.S. Pivotal Trial in 2013, we saw for the first time superiority in survival with TAVR when compared to surgical valve replacement at one year.

Another important question to ask is: "We are helping these patients live longer, but what kind of quality of life do they have?"

The good news is that patients do very well. As shown in the table on page 11, the vast majority of patients prior to treatment were classified as a Class 3 or 4 functional capacity, and in both the partner trial and the CoreValve high-risk trial, the vast majority of these patients (>90%) became Class 1 or 2 functional capacity at one year. This is a very impressive improvement in quality of life.

Benefits at a Glance

In summary, TAVR brings the following benefits to the table:

- Equal or higher survival to open heart surgery.
- Significant improvement in functional class and quality of life.
- Better economics to government and the Centers for Medicare and Medicaid Services, with lower rehospitalization rates and cost of care, faster recovery and shorter hospital stays.
- Less burden on caring family members, and more opportunity for patients to enjoy life with their loved ones.

If you have a patient diagnosed with aortic valve stenosis and question the risk of open heart surgery, remember to ask about TAVR. It can be a life-saver in more ways than one.

For more information, contact Dr. Kassas at 989.754.3000 or safwankassasMD@aol.com.

As human beings who treat other human beings, we've all had patients at one time or another with symptoms of being constantly short of breath or having chest pain. Today, we have a new tool for high-risk patients called TAVR.

HOW TAVR IMPROVES QUALITY OF LIFE

	>90% OF PATIENTS IMPROVE AT 1 YEAR	
FUNCTIONAL CAPACITY OF PATIENTS	**BEFORE TAVR**	**AFTER TAVR**
	Class 3 Patients with cardiac disease resulting in MARKED limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue and other issues.	**Class I** Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does NOT cause undue fatigue or other major issues.
	Class 4 Patients with cardiac disease resulting in the INABILITY to engage in physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If ANY physical activity is undertaken, discomfort is increased.	**Class 2** Patients with cardiac disease resulting in SLIGHT limitation of physical activity. They are comfortable at rest. Ordinary physical activity, however, causes fatigue and other issues.

When a cancer is suspected in a patient,
it is the tissue that holds the key to further management.

The Tissue Is the Issue
Thinking Ahead When Diagnosing Cancer

GUEST AUTHOR
Dr. Binu Malhotra, Oncologist, Covenant Cancer Care Center Physicians

When a cancer is suspected in a patient, it is the tissue that holds the key to further management. It not only establishes the diagnosis but also helps stage the disease and plan treatment.

Oftentimes, however, we are caught by surprise, forgetting to think ahead. We have all admitted and cared for patients who had incidental findings discovered upon imaging. For example, it is not uncommon to notice a lung mass on a CT ordered for diagnosis of pulmonary embolism, or a mass in the pancreas on a CT ordered for a workup of abdominal pain.

Rarely are we ordering those scans with the intent of diagnosing a mass that could be cancer, yet we are faced with these "surprise results" every day of our working life. Very often, we are talking to our patients about how their CT did *not* show a pulmonary embolism but unfortunately it *did* show a 4 cm lesion in the right upper lobe of the lung and mediastinal lymphadenopathy.

Thinking Ahead

The next step is obviously a biopsy of the mass, the unexpected finding, to confirm or refute our fears. Everyone, the physician and the patient, is anxious to know if the abnormality on a scan could be cancer!

Rarely, however, are we thinking ahead about staging the disease with that biopsy. If we see a lung mass with mediastinal and supraclavicular lymph nodes, a biopsy of the lung mass could diagnose cancer, but the job is only partially done. Alternatively, when we biopsy the supraclavicular lymph node, we have now diagnosed *and* staged the cancer in one procedure. We just saved our patient a second biopsy and the potential side effects from an additional procedure.

Similarly, if we see a lung mass, mediastinal lymph nodes and liver lesions, we need to use our best judgment to establish the most likely primary organ of disease, and then target the site that would represent metastasis and thereby stage the disease.

Unfortunately, this is not always straightforward and the risks and benefits must be weighed. For example, a liver biopsy can be technically difficult if there is a small lesion which is hard to access. Also, bone biopsies can be notoriously inadequate for establishing a tissue diagnosis and molecular testing.

Adequacy of Biopsy Specimen

Another issue involves the adequacy of the biopsy specimen, a vital step in the diagnosis and management of cancer. When ordering a biopsy, it is important to consider the accessibility of the site for biopsy and the yield on the biopsy specimen.

While fine needle aspiration (FNA) might suffice for diagnosing a carcinoma versus benign tissue, it is rarely adequate for learning additional information. In this era of personalized medicine, treatment can only be personalized if there is adequate tissue to run genetic/molecular tests on the specimen.

We routinely test for receptor overexpression, genetic mutations and deletions before planning treatment. In certain situations such as lymphomas, we need to look at the architecture, perform a chromosomal analysis, and conduct other tests to plan the treatment, requiring at least a core biopsy. A core biopsy is optimal for diagnosis and treatment, while FNAs almost never suffice and are inadequate for diagnosing lymphomas.

Reducing Stress and Risk

A diagnosis of cancer, or even a suspicion of cancer, is agonizing news. Once we diagnose someone with cancer, the process of staging, referring to the specialist, learning about the disease and learning about the treatment, is overwhelming.

If we are able to remove just one step, a second biopsy and in some cases, the additional risk of complications from the additional biopsy, we would do a huge service to our patients. We are not only reducing risk, but also stress. Furthermore, it is a step in the right direction in improving the utilization of available resources.

So the next time you are faced with an incidental finding that could be cancer, remember to plan ahead for the patient. Be proactive to reduce the number of biopsies needed to diagnose and stage the disease. This will not only lead to a diagnosis and treatment plan sooner, but also save time and stress for everyone involved.

For more information, contact Dr. Malhotra at 989.751.9785 or bmalhotra@chs-mi.com.

If we are able to remove just one step, a second biopsy and in some cases, the additional risk of complications from the additional biopsy, we would do a huge service to our patients.

What Goes Around Comes Around
The Value of Physician-Nurse Rounding

GUEST AUTHOR
Alan Spencer, Director Medical/Surgical Services

There is no question that collaboration among healthcare professionals is critical to improving the quality of patient care, but one key tactic for driving results is often overlooked: Physician-Nurse Rounding. This unified, team approach puts the patient at the center of attention and is proven to improve collaboration and outcomes. Truly, what goes around comes around as the impact of Physician-Nurse Rounding adds value to everyone involved.

If you are not finding the time to implement this approach, then check out some of the myths versus realities of Physician-Nurse Rounding on page 15.

Key benefits include:

- Places the patient at the center of collaborative care.
- Helps patient care become more coordinated and efficient.
- Saves time and frustration for everyone, reducing calls to physicians and nurses.
- Presents a strong team image to patients, boosting confidence in their care.
- Improves communications between professional caregivers, and with the patient and families.
- Increases patient and physician satisfaction.

It might not feel natural for physicians and nurses to round on patients together – especially if it's not a part of your routine or seems difficult to coordinate. It is, however, a great way to collaborate and is well worth the effort.

How it Works

Ideally, the physician and nurse review the patient's chart in advance. The nurse informs the physician about the patient's current condition and any concerns, enabling the physician to get the full, up-to-date patient picture. Treatment is discussed before entering the room.

This way, both parties are on the same page and can educate the patient together. The nurse hears, in real time, what the physician is saying to the patient, and can provide clarity to the patient in case patients or their families ask questions later. Because patients are not hearing different things from the physician and nurse, there is less confusion. Patient calls to the nurse are typically reduced as are follow-up calls from the nurse to the doctor.

Physician-Nurse Rounding is known in the industry as a best practice. It brings the two most involved members of the care team together to collaborate on their patient's care to deliver the best outcomes.

Physician-Nurse Rounding isn't anything new, but unfortunately, it is easy to put aside. When you do this, however, you are only hurting yourself in terms of inefficiency, plus you could be hurting the patient by not getting the whole story. Electronic technologies have their benefits, but sometimes, things can be overlooked or lost in translation.

Finding the Right Balance

Success is all about finding the right balance, which absolutely must include face-to-face collaboration and interaction with your peers. Physician-Nurse Rounding is known in the industry as a best practice. It brings the two most involved members of the care team together to collaborate on their patient's care to deliver the best outcomes.

So **physicians**, before you visit a patient, please consider talking to the nurse in advance about rounding with you. The Health Unit Coordinator can assist in locating the nurse, and you can also disclose your rounding times in advance, especially if you have a majority of patients on a particular unit. And **nurses**, take the initiative to bring up the topic with physicians in advance of their rounds, and to discuss a possible path for rounding success.

By becoming better partners in collaboration, we can take positive patient experiences to new levels.

For more information, contact Alan Spencer at 989.583.6322 or aspencer@chs-mi.com.

Truly, what goes around comes around as the impact of Physician-Nurse Rounding adds value to everyone involved.

PATIENT ROUNDING: MYTHS VERSUS REALITIES

MYTH	REALITY
It is a waste of time in an already busy schedule.	Rounding actually saves time by minimizing call-backs and clarifications.
Patients don't care about seeing the physician and nurse together, just getting better.	Rounding minimizes patient worries about disconnects and hand-offs, reinforcing a team image while enhancing patient confidence. Lower patient anxiety also improves the speed of recovery.
Physicians and nurses can connect electronically instead.	This is true, except for the word "instead." Nothing can take the place of face-to-face verbal communication. Rounding fills in the blanks, drives transparency and improves patient safety.
Physician-Nurse Rounding is not the normal hierarchy of things.	Hierarchies and silos don't help a patient; developing professional relationships and mutual trust do. Rounding brings us together on common ground, which is to deliver quality care and a healthier patient.
If we do multi-disciplinary rounds, we don't need Physician-Nurse Rounds.	Physician-Nurse Rounds are a subset to larger team rounds, and can be easier to coordinate. Consequently, they can be more personal and frequent, and a more comfortable setting for the patient to ask questions.

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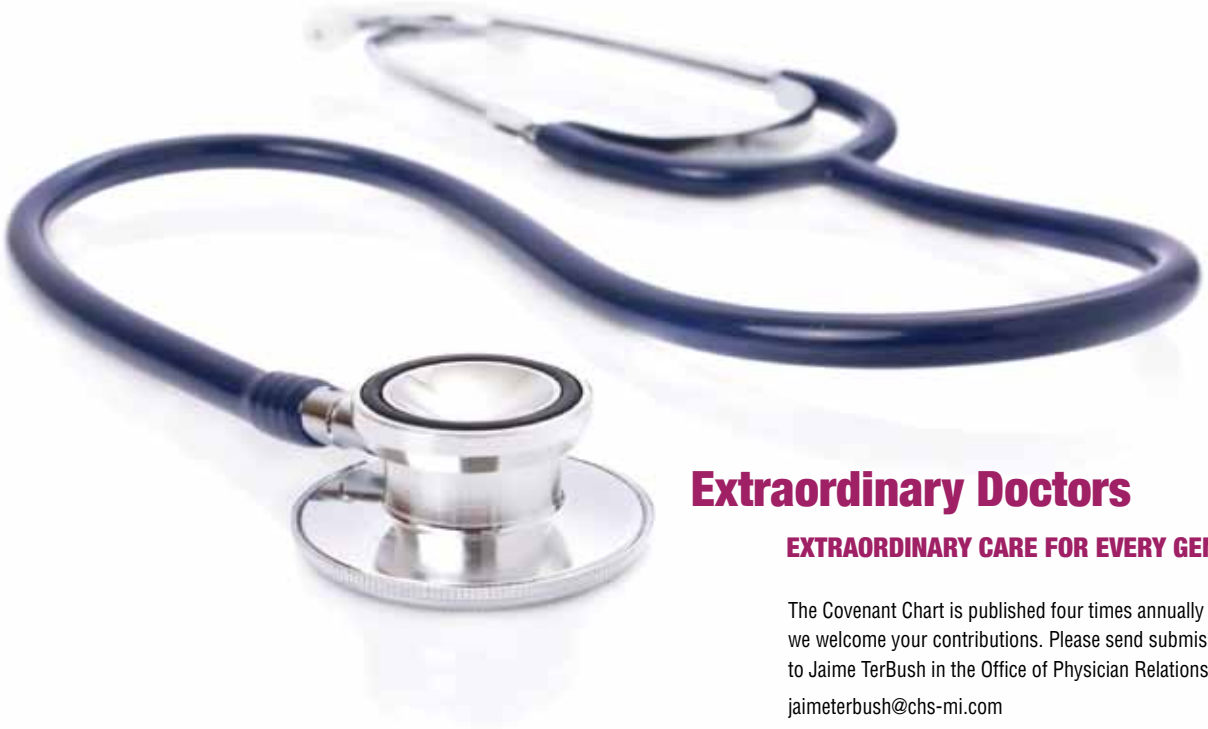

Extraordinary Doctors

EXTRAORDINARY CARE FOR EVERY GENERATION

The Covenant Chart is published four times annually and we welcome your contributions. Please send submissions to Jaime TerBush in the Office of Physician Relations.

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