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Entering our Fifth Year of The Covenant Chart Help Make it Better!

Dr. Sara Rivette, Covenant HealthCare Chief of Staff

In June 2010, the first issue of *The Covenant Chart* hit the desks of Covenant HealthCare medical staff. It was borne out of a 2009 physician satisfaction survey in which physicians asked for improved communications, a request that has been reinforced in subsequent surveys.

The Covenant Chart was designed to meet that need with articles that keep physicians informed about new technologies, treatments, philosophies, industry issues and more.

Four years later, 17 quarterly issues of *The Covenant Chart* have been published featuring 180 articles written by nearly 100 physicians. Three chiefs of staff have presided over the effort – Drs. Peter Fattal, Kristin Nelsen and myself. Today, the publication is not only available by email and print, but also is published on www.covenanthealthcare.com under Physicians / Newsbrief-The Chart.

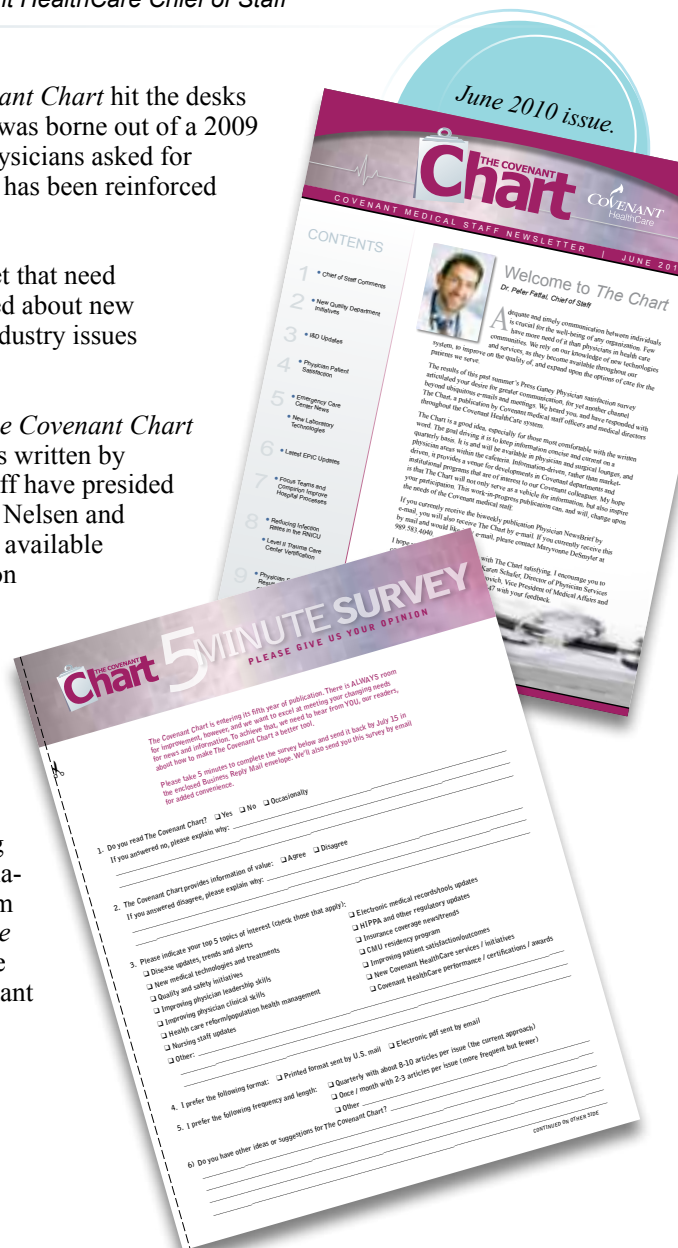
A big THANK YOU is extended to contributors, readers and editors for making this publication a success!

There is always room for improvement, however, and we want to excel at meeting your changing needs for news and information. To achieve that, we need to hear from YOU, our readers, about how to make *The Covenant Chart* a better tool. Please share your opinions by completing “The Covenant Chart Survey” on pages 13 and 14 of this issue and returning it in the enclosed pre-paid envelope to us by July 15, or look for an email version in your inbox soon.

Thank you,

Sara Rivette MD

Dr. Sara Rivette, Chief of Staff





Avoiding Acute Compartment Syndrome

Vigilance Prevents Injury

GUEST AUTHOR
 Dr. Michael Tucker, Orthopaedic Traumatologist

While rare, acute compartment syndrome (ACS) affects around 200,000 people in the U.S. It is a disastrous and preventable complication of trauma that is difficult to diagnose. It is therefore critical to be vigilant with trauma patients and obtunded patients to prevent irreversible injury, amputation and death.

ACS typically occurs when excessive bleeding or swelling after surgery or a traumatic injury increases the pressure in the limbs, buttocks, thigh or foot, compromising circulation, tissues and function. There is some evidence that larger muscle volumes are a risk factor, making men more susceptible to this condition than women.

Pathophysiology

ACS occurs when an increase in hydrostatic pressure in closed osteofascial spaces results in decreased perfusion of muscle and nerves within the compartment. Pressure increases in the compartment until the low intramuscular arteriolar pressure is exceeded, and blood cannot enter the capillaries. This can result in nerve or muscle damage, or tissue death.

Compartment syndrome of leg treated with fasciotomy.



Causes of Ischemia

Key causes of ACS include:

- Fractures, which account for 75% of ACS cases
- Hemorrhage, usually due to fractures of the tibia, elbow, forearm or femur
- Swelling from traumatized tissue
- Soft tissue “crush” injuries
- Increased fluid secondary to thermal burns
- Arterial injury, including post-ischemic swelling and reperfusion injury
- Drug overdose (limb compression)
- Overly constrictive casts and dressings

Patients and extremities at highest risk are shown in Table 1, while Table 2 shows the impact of ischemia over one to eight hours. After four hours, myoglobinuria can occur leading to renal failure, and after eight hours the changes are irreversible as cell death takes hold, initiating a vicious cycle of increased capillary permeability and muscle swelling/edema in the surrounding tissues.

Diagnosis

ACS is difficult to diagnose. The classic 5 P’s – pain, pallor, paralysis, pulselessness and paresthesias – are not reliable. Palpable pulses, for example, are usually present unless an arterial injury occurs, and sensory changes and paralysis do not occur until ischemia has been present for one hour or more.

The best strategy is to maintain a high degree of suspicion for patients at risk, and to perform frequent serial exams. Diagnosis should also include the patient’s history and pain threshold. The most important symptom is pain that is:

- DISPROPORTIONATE to that expected for the injury
- Present with passive muscle stretching
- Progressive
- Not relieved by immobilization
- May worsen with elevation
- Causes the patient to avoid initiating motion

TABLE 1: HIGH-RISK CONDITIONS AND EXTREMITIES

High-Energy Fractures	Impaired Sensorium	Common Extremities
Involving severe comminution, joint extension, segmental injuries, wide displacement, bilateral injury, floating knee and open injuries	Involving alcohol, drugs, decreased GCS*, unconsciousness, neurological deficits, cognitive challenges *Glasgow Coma Scale	Include the leg, especially the deep posterior and anterior compartments. Also the forearm volar compartment, especially in the deep flexor area

TABLE 2: IMPACT OF ISCHEMIA OVER 1-8 HOURS

Time	Muscle Damage	Nerve Damage	Other
1 hour	Reversible	Normal conduction	
1-4 hours	Reversible	Neuropraxic damage reversible	
4-8 hours	Variable	Variable	Myoglobinuria and renal failure
8 hours	Irreversible changes	Axonotmesis and irreversible changes	

Compartment pressures are another indicator of ACS and may be measured to confirm diagnosis and treatment. Several techniques are available with the most frequent being a handheld manometer (Stryker device), a simple needle manometer system, and the wick or slit catheter technique.

Interpreting the measurement properly is critical. Normal resting muscle tissue pressure is as high as 4 mmHg and 8-10 mmHg with exertion, while exercise-induced ACS may have a resting baseline of 10-15 mmHg. Signs of ACS develop as tissue pressure within the affected compartment approaches the diastolic blood pressure (DBP).

Many studies have established a better understanding of the thresholds of ischemia. Most experts today recommend using a difference between the DBP and the compartment pressure of 30 mmHg or less as the threshold for an elevated compartment pressure. Some physicians, however, still use an absolute pressure greater than 30 mmHg, but this can be misleading because higher pressures may be necessary before injury occurs to the peripheral nerves in patients with systemic hypertension. Conversely, ACS can occur at lower pressures in patients with hypotension or peripheral vascular disease.

Treatment & Fasciotomies

When ACS is suspected, urgent surgical consultation is in order. Immediate treatment steps include removing restrictive covering, not elevating or putting stress on the limb, and placing the limb at a level with the heart. Analgesics and supplementary oxygen can also be provided.

In most cases, a fasciotomy to fully decompress the compartments is necessary, followed by potential skin grafts and hyperbaric oxygen to promote healing. Delays in performing

Tissue pressure is monitored using portable hand-held devices such as the Stryker model with a side-port needle.



a fasciotomy can lead to amputation or death. Occasionally, a fasciotomy may not be necessary, such as when the muscle is already dead and surgery provides no benefit.

Prognosis

As with most conditions, the earlier the diagnosis and treatment of ACS, the better the outcomes – both functional and cosmetic. Although not common, complications such as renal failure can lead to death, especially in severe trauma cases – another reason to always be vigilant with high-risk patients.

For more information, contact Dr. Tucker at 989.583.7450 or mtucker@chs-mi.com.



Actions to Improve Physician Engagement

Dr. Michael Schultz, Vice President of Medical Affairs

After evaluating the results of the 2013 Physician Engagement Survey, Covenant HealthCare continues to move forward with three improvement opportunities designed to help create the most attractive environment for practicing medicine. These opportunities are shown in Table 1 along with key actions and owners.

In addition, we have received open-ended feedback from the survey which is appreciated. Those comments are being collated and will be carefully evaluated to help provide additional guidance in the formulation of future improvement planning.



**TABLE 1
ACTION PLAN FOR PHYSICIAN ENGAGEMENT**

TOP IMPROVEMENT OPPORTUNITIES	KEY ACTIONS	ACTION PLAN OWNER
<p>1 Disruptive behavior is not tolerated at Covenant HealthCare.</p>	<ul style="list-style-type: none"> • Continue use of Physician Safety Leadership Team and Peer Advisory Council as a vehicle to address the situation. • Provide training to Peer Advisory Council for Disruptive Behavior and clarify expectations of their role as coaches. • Improve efficiency and effectiveness with the Medical Staff's Disruptive Practitioner Policy. 	<p>Dr. Michael Schultz Dr. Michael Sullivan</p>
<p>2 Covenant HealthCare makes patient safety a priority.</p>	<ul style="list-style-type: none"> • Continue roll-out of HRO initiative, including physician participation through Physician Safety Leadership Team. • Complete HRO education for existing medical staff and incorporate into onboarding of all new members of the medical staff. • Utilize all physician communication vehicles to educate/update physicians on HRO initiative. 	<p>Dr. Michael Schultz Dr. Michael Sullivan</p>
<p>3 I am kept informed of Covenant HealthCare's strategic plans and direction.</p>	<ul style="list-style-type: none"> • CEO/Administration to continue updating the following groups on strategic direction: Medical Staff Officers, Medical Executives, Covenant Medical Group, Covenant Physician Organization, Active Medical Staff. • Email blasts from Administration with strategic updates. 	<p>Spence Maidlow</p>

What's New In ...

Disruptive Behavior Training

The Physician Safety Leadership Team was created as part of the infrastructure to become a High Reliability Organization (HRO). The team agreed that one key area of focus is disruptive behavior, and is therefore developing a Physician Peer Advisory Team focused on intervention strategies that diffuse disruptive behavior incidents in a timely fashion. The team is developing tools to have constructive conversations with physicians who are involved in disruptive incidents.



Patient Safety

Participation in HRO training continues. Since January, approximately 510 physicians, physician assistants and nurse practitioners have been trained – or about 80% of that total population. This is in addition to numerous residents and medical students who have attended training as well.

Another component of the high reliability initiative at Covenant HealthCare is the promotion of safety to administrative staff through “safe” email communications that highlight actual incidents, lessons learned, solutions and next steps. Staff then take action to avoid similar repeated events.

Such incidents are also covered in the Daily Check-In (DCI) for Safety sessions, which are now scheduled every day of the week. Stop by the Bickel-Geyer Conference Room at Cooper on Monday-Friday at 9 am or Saturday-Sunday at 10:30 am to observe the action.



Strategic Direction

February marked the start of a CEO email blast campaign in which strategic updates are sent to the entire medical staff after each Active Medical Staff meeting. If you are not receiving these emails, please contact Patti Roesner at 989.583.6595 in Medical Staff Services to ensure we have your correct email on file.



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



Lung Cancer Screening Beneficial in Selected Patients *Coverage Still a Challenge*

GUEST AUTHOR

Dr. Jay Nayak, Oncologist, Covenant HealthCare

Lung cancer is the third most common cancer in the United States and the leading cancer-related death usually occurring in persons aged 55 years or older. The primary risk factor for lung cancer is tobacco smoke exposure, which results in about 85% of all cases in the United States.

Unfortunately, lung cancer has a high mortality rate of about 90%. Early-stage non-small cell lung cancer (NSCLC), however, has a better prognosis and can be successfully treated with surgical resection with or without chemotherapy if caught in time. Yet only 15% of lung cancer cases are detected early enough, partly due to the aggressive nature of lung cancer and the lack of sensitive screening methods. Multiple studies show, for example, that chest radiology and sputum cytology evaluation are inadequate and inaccurate.

There is light on the horizon, however, the U.S. Preventive Services Task Force (USPSTF)* has recently recommended annual low-dose computed tomography (LDCT) screening as a standard preventative procedure for lung cancer based on a first-ever National Lung Screening Trial (NLST) proving the benefit of lung cancer screening.

Study Shows LDCT Screening is Promising

The NLST, which was published in the New England Journal of Medicine** in 2011, confirmed the benefit of LDCT in reducing the mortality of high-risk patients. Data was gathered from over 53,000 asymptomatic adults aged 55 to 74 years who had at least a 30 pack/year smoking history and were still smoking, or who had quit in the past 15 years. Enrollment began in August 2002 and data collection occurred through December 2009. Participants were randomized between an LDCT scan and a chest radiography. They received annual screening tests for three years and were followed for five years, and the rate of adherence was more than 90%.

High-level results are as follows:

- There were 247 deaths from lung cancer (per 100,000 person-years) in the LDCT group and 309 deaths in the radiography group, representing a **20% reduction in mortality from lung cancer with LDCT screening**. The number needed to screen (NNS) to prevent one lung cancer death was 320 among participants who completed one screening.
- The rate of death from any cause was reduced by 6.7% in the LDCT group, as compared with the radiography group. The NNS to prevent one death was 219.

Note that while several trials had been done prior to the NLST, the quality and results of the NLST are what triggered the USPSTF to seriously review seven randomized controlled trials of LDCT as a screening tool, including:

- DANTE – Detection and Screening of Early Lung Cancer by Novel Imaging Technology and Molecular Essays
- DLCST – Danish Lung Cancer Screening Trial
- MILD – Multicentric Italian Lung Detection

Because screening with LDCT is proven to reduce mortality, it is now endorsed by the:

- National Comprehensive Cancer Network
- American College of Chest Physicians
- American Society of Clinical Oncology
- American Cancer Society

Screening Eligibility and Risks

While smoking cessation is the primary way to prevent lung cancer, the USPSTF recommends annual screening for lung cancer with LDCT in high-risk adults aged 55-74 years who have a 30 packs/year smoking history and still smoke, or have quit within the past 15 years. Screening is not recommended for people who have not smoked for 15 years or are experiencing another significant life-limiting comorbidity.



Risks of screening could include:

- Anxiety associated with detecting abnormalities that are not cancer (false positives). LDCT scans find abnormalities in 20-60% of smokers and former smokers. These are often scars from inflammation or other noncancerous conditions.
- Harmful effects of radiation exposure: 0.61 to 1.5 mSv per scan.

Should LDCT detect a localized NSCLC, the current standard of care applies: surgical resection in conjunction with radiation and chemotherapy when possible.

Coverage Remains a Challenge Despite Strong Supporting Data

Medicare is the primary insurer for patients in the screening age group. Recently, the Centers for Medicare and Medicaid Services (CMS) accepted two formal requests to initiate a National Coverage Analysis on LDCT but unfortunately, coverage was denied at a recent Medicare Evidence Development and Coverage Advisory Committee (MedCAC) meeting despite strong recommendations from several pulmonary and oncology physician organizations.

That said, physicians should still seriously consider LDCT screening for at-risk patients. While Medicare coverage is not yet available at this time, this issue is going to be revisited and providers are feeling optimistic that coverage will be approved.

In addition, it is likely that many private insurances may be covering LDCT for eligible patients under the Affordable Care Act as a preventive service and will most likely have coverage starting January 2015.

Summary


LDCT screening represents a milestone in lung cancer diagnostic techniques. It is the first type of screening that is proven to improve the survival of lung cancer patients. Consequently, it is also the first time the USPSTF is recommending screening for lung cancer. If you have patients who fit the screening profile, remember to consider the LDCT as part of early prevention and treatment.

For more information, contact Dr. Nayak at 989.583.5060 or jnayak@chs-mi.com. Also see the footnotes for more resources.

FOOTNOTES

*<http://www.uspreventiveservicestaskforce.org/uspstf13/lungcan/lungcanfinalrs.htm#consider>

**<http://www.nejm.org/doi/full/10.1056/NEJMoa1102873>



The primary risk factor for lung cancer is tobacco smoke exposure, which results in about **85%** of all cases in the United States.



Transitional Care A Safe Journey Home

GUEST AUTHORS

Dr. Kelsey Knack, Physician Champion for Covenant HealthCare Transitions Initiative, and
Dr. Kimiko Sugimoto, Surgeon Champion for MSQC and Partnership for a Better Recovery Program

How Two Covenant HealthCare Initiatives are Providing a Safe Transition for ALL Patients

Recently, there has been increasing interest surrounding the movement of patients between care providers or care settings, an experience otherwise known as “care transitions.” Much of this conversation has been framed around the problem of readmissions, largely because Medicare and other payers are penalizing organizations for high readmission rates. Consequently, initial transitional care efforts have focused on improving the hospital discharge process.

However, the more we learn about the care transition experience, the more we find that it goes beyond readmissions and discharge to include the safety of our patients during a difficult time, ensuring they have the resources and support they need to safely move within the healthcare system. It also goes beyond the hospital to encompass the patient’s movement across the care continuum, which includes the primary care provider (PCP), specialists, skilled facilities and community resources.

This article covers two initiatives that are providing a safer transition for all patients: Covenant HealthCare Transitions and Partnership for a Better Recovery.

First, the Scope of the Problem

Most physicians have been involved in the care of a patient discharged from the hospital who returns sometime later with a seemingly avoidable complication. There are a variety of reasons patients return to the hospital, including a lack of understanding of their medication, lack of support in the home or difficulty with symptom management.

Hospitalization impacts the patient and their loved ones physically, emotionally and financially. The failure of a patient to safely transition can lead to a pattern of readmission that leaves the patient weaker, emotionally distraught and financially stressed.

While transitional care is more than just readmissions, understanding the scope of the readmission problem explains why it is a focus of healthcare reform. According to various reports:

- Hospitalizations account for nearly one-third of the total \$2 trillion spent on health care in the United States.
- It is estimated that 20% of Medicare hospitalizations are rehospitalizations within 30 days of discharge.
- The Medicare Payment Advisory Commission (MedPAC) conducted an analysis of Medicare beneficiaries and found that up to 76% of rehospitalizations occurring within 30 days of discharge are preventable.

Clearly, this is an issue for our payer sources and as a result, has become an issue impacting the bottom line of healthcare providers.

INITIATIVE #1

Covenant HealthCare Transitions

What It Is

Covenant HealthCare’s participation in the Michigan Transitions of Care Collaborative (MT-C²) has brought to our attention Project BOOST (Better Outcomes by Optimizing Safe Transitions), a successful initiative to enhance safe transitions. Project BOOST provides useful, evidenced-based resources to optimize the hospital-to-home transition, and is the core of our own transitional program called Covenant HealthCare Transitions (CHCT).

The vision for CHCT is to reach across the physical boundaries of the hospital to enhance patient safety and satisfaction with the transition from the hospital to the community care providers. This will be accomplished by ensuring that all hospitalized patients receive some form of transitional care.

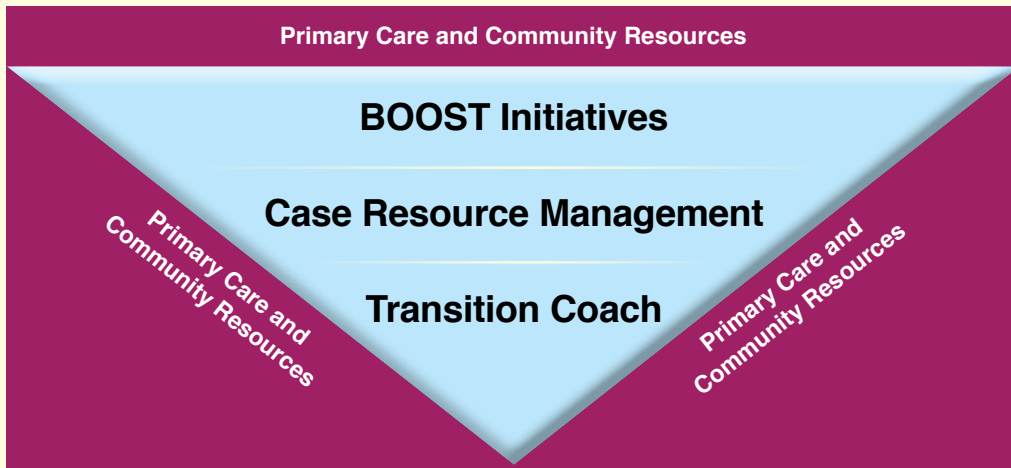
Key Goals

CHCT goals are as follows:

- Enhance current tools and assessments utilized by the hospital to effectively evaluate, anticipate and meet the patients’ needs post discharge.
- Improve communication flow with our community partners.
- Increase patient satisfaction with discharge/transition experience.
- Reduce overall readmissions.
- Reduce readmissions in two key target areas: Congestive Heart Failure and Chronic Obstructive Pulmonary Disease.

CHCT is a multidisciplinary approach that will be implemented across the hospital over the next 18 months. It offers general, proven interventions for improving transitions along with more specific, targeted interventions for identified areas of high risk in our patients. Together, these components will address the needs of all patients and include:

- **Follow-up appointments** scheduled with the primary care provider within seven days of hospital discharge. The evidence suggests that timely discharge follow-up within seven days can reduce the risk for readmission.
- **Medication reconciliation** with each care transition including post discharge. A clear understanding of current medications and changes that have been made will assist in the reduction of adverse events during and after hospitalization.
- **Teach-back** for all patient education. Teach-back is a closed-loop communication technique which has been proven to enhance patient understanding of education necessary for self-care.
- **Discharge summaries** within seven days or prior to first follow-up appointment. This initiative will enhance flow of information with our community partners.
- **Follow-up phone contact** on all high-risk patients, ensuring medication reconciliation and follow-up care has been arranged with the primary care provider.



The vision of CHCT is to reach across the physical boundaries of the hospital to enhance patient safety and satisfaction with the transition from the hospital to the community care providers.

is a closed-loop form of communication where the teacher continues to evaluate understanding and restate the information until it is retained.

This technique emphasizes quality conversations with both patients and their families, revealing to practitioners possible gaps in patient understanding. Importantly, it is shown to not only improve patient understanding, but to also enhance both patient and physician satisfaction with the overall experience.

Bonnie Hartwick, RN, will provide Teach-Back instruction to all Covenant HealthCare nurses as part of the CHCT initiative. According to Bonnie, who has been involved with care transitions since 2010, “Teach-Back is being embraced by Covenant HealthCare as THE way to communicate with patients and families on all healthcare related issues, and I’m excited to promote its use across the organization.”

Teach-Back is also bringing great value to physician practices. Evidence suggests that it promotes a more efficient and effective bedside interaction. Several Covenant HealthCare physicians currently utilize Teach-Back in their daily practice (see Personal Commentary on page 11) and resources are available to coach interested physicians. To learn more, feel free to contact any of the team members listed below.

For more information about the Covenant HealthCare Transitions initiative, contact any of the following:

- Dr. Kelsey Knaack, CHCT Physician Champion at 989.583.4220 or kknaack@chs-mi.com
- Suzanne Dole, Director of Patient Safety and Quality at 989.583.6176 or sdole@chs-mi.com
- Karen Bush, Nurse Practitioner at 989.583.4023 or karenbush@chs-mi.com.
- Bonnie Hartwick, RN at 989.583.6487 or bhartwick@chs-mi.com

Collaboration & Coaching

CHCT emphasizes collaboration and a multi-disciplinary response. The transition team and case management have partnered to create a document for case management to identify specific risk factors within our patient population. Once identified, these risk factors will trigger a multidisciplinary response with the goal of modifying that risk.

The transition coach is the final piece of the CHCT vision. These coaches work with high-risk patients and their families during the hospital stay. The goal is to provide diagnosis-specific support to:

- Promote self-care management of chronic disease.
- Emphasize the use of community resources.

This care extends beyond hospitalization in the form of phone contact for 30-40 days post discharge. According to Karen Bush, nurse practitioner for CHCT, “Transitions of care is about looking at the patient in the here and now and visualizing them 30 days from now, then addressing all of the needs that you can anticipate within that 30-day window.”

Teach-Back as a Provider Tool

The CHCT initiative emphasizes Teach-Back as an effective communication tool during patient encounters. The Teach-Back process is widely endorsed as an essential safe practice because it requires patients to repeat back, in their own words, information shared with them by health providers. It

INITIATIVE #2

Partnership for a Better Recovery

As part of improving the continuum of care, Covenant HealthCare is also focused on improving patient outcomes and readiness prior to surgery via the “Partnership for a Better Recovery” program. This program was developed through a recommendation of the Michigan Surgical Quality Collaborative’s (MSQC) Enhanced Recovery Program (ERP).

Elements include:

- Educating patients for healing and recovery in seminars that cover everything from smoking cessation and diabetes management to nutrition and pulmonary/respiratory care (see Figure 1).
- Reducing pre- and post-operative anxiety.
- Providing a package of important tools, checklists and resources.
- Preparing them for discharge and home expectations.
- Empowering them to control their care.

Covenant HealthCare Partnership for a Better Recovery

EDUCATIONAL SEMINARS

Having Surgery? Please join us for a FREE 1-1.5 hour pre-op seminar providing education to help:

- Ease your apprehension
- Establish your expectations
- Make your recovery easier and smoother

How you can help to improve your surgical outcomes.

Stop Smoking	Smoking increases your chance of breathing problems and pneumonia after surgery. Try to stop at least two weeks prior to surgery.
Walk Daily	Walking strengthens your heart and lungs in preparation for and recovery from surgery.
Eat Healthy	Protein-rich foods are good nutritional choices. Avoid foods that are high in sugar and fat. Keep hydrated.
Control Diabetes	If you are diabetic, check your blood sugar, take your medication and follow your diet. Ask about getting your hemoglobin A1C checked.
Medications	Make sure your surgeon and the hospital know all of the medications you are taking.
Cough and Deep Breath	This moves mucous out, strengthens respiratory muscles and clears your lungs. Cough and breath deep several times daily.
Incentive Spirometer	Use of an incentive spirometer strengthens respiratory muscles and improves lung function.
Keep Head Up	Sit in a chair and walk to improve lung function, expand lungs and reduce congestion.
Shower	Shower with antibacterial soap for the three days prior to and on the morning of surgery to help prevent infection.
CHG Cloths	Use the CHG cloth wipes in the hospital the day of your surgery to help prevent infection at the surgical site.
Oral Hygiene	Use mouthwash and brush teeth twice daily for the two days before and on the morning of surgery to reduce harmful bacteria in the mouth and reduce chance of pneumonia.
Get Lab Tests	If you are required to get lab tests, get them as soon as possible.

EDUCATE, EMPOWER AND ENGAGE
You are the most important member of the team... we are empowering you to be educated and engaged in your care!
Ask your physician about attending one of our FREE pre-op educational seminars.

For more information, please call 989.583.7385 or e-mail us at presurgedu@chs-mi.com.

COVENANT HealthCare
Extraordinary care for every generation.

FIGURE 1: SEMINAR TOPICS

Partnership for a Better Recovery provides educational seminars to reduce health risks prior to surgery, which in turn helps decrease readmissions and improve quality of life.

Covenant HealthCare Partnership for a Better Recovery

Surgical High-Risk Criteria Quick Reference Guide

If your patient answers “yes” to any of the following criteria, you should recommend they attend a Partnership for a Better Recovery FREE Educational Seminar:

1. Is your age > 50?
2. Do you have a history of cardiac disease?
3. Do you have pulmonary disease?
4. Are you diabetic?
5. Is your BMI > 30?
6. Do you use steroids?
7. HX CA?
8. Do you receive dialysis?
9. Do you smoke?

Remember to give your surgical high-risk patients details for attending a Partnership for a Better Recovery FREE seminar.

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Bus Div (42/95) 014 P08/19

FIGURE 2: CRITERIA FOR SEMINAR ATTENDANCE

Partnership for a Better Recovery seminars are especially ideal for patients who are at risk.

Importantly, this program is:

- **Patient-focused.** It is designed to answer patient questions while providing a support system during the pre- and post-operative period. It promotes patients as the center point of the healing process and the most important member of the team, empowering them to engage in their care – to control what they can control.
- **Outcomes-based.** A primary goal is to decrease the number of complications during routine surgery by minimizing patient confusion and clarifying expectations, especially among high-risk patients. Increasing their confidence can decrease length of stay (LOS), post-op complications and readmission rates while improving HCAHPS scores.
- **A complement to physician-provided education.** While participating in this program is not mandatory, it is highly recommended as another resource for patients to understand the surgical process. It is designed to assist, not replace, the surgeon’s role as key patient educator.

Programs like this are shown to increase savings among all parties, increase reimbursement and improve rankings in public reporting.

The process for getting your patients started is simple. After a patient is seen for a surgical consult and is assessed as high risk, the surgeon or PCP should notify Covenant HealthCare to schedule the patient for the Partnership for a Better Recovery seminar one to four weeks prior to surgery. If a patient does not meet the criteria for attendance shown in Figure 2, physicians can still schedule the patient if they feel the patient can benefit.

For more information about:

- The patient-centered Partnership for a Better Recovery Program, contact Dr. Sugimoto at 989.790.4855 or kimikos@kerio.mmssurgery.com.
- Scheduling your patients for a Partnership for a Better Recovery Seminar, contact Dawn Grauf, Program Administrator, or Jessica House, Program Nurse Educator, at 989.583.7385 or email presurgedu@chs-mi.com.

Personal Commentary

– FROM DR. KNAACK

“I can personally attest to the value of the Teach-Back method which I have employed in my practice for several years. This simple communication technique has provided me with the opportunity to gain valuable insight into the level of patient understanding about all things healthcare related.

Whether explaining a new diagnosis of atrial fibrillation or discussing a scheduled radiologic procedure, Teach-Back allows me to first assess the patient’s knowledge on the subject and then offer targeted education. I then ask the patient to demonstrate their understanding of what they heard. If knowledge gaps are identified, I find it very important to reframe the education and continue the Teach-Back loop until the patient has mastered the information or concept that I am trying to convey.

I will often close the conversation with an open-ended question such as, “I want to make sure that I explained things clearly, can you tell me about the procedure that you are scheduled for today?” This gives me the chance to evaluate whether my education was effective for the patient and validates their comprehension.

There is no question that the Teach-Back technique has enhanced the patient care setting. It is very gratifying leaving a bedside encounter with the assurance that my patient truly understood the information necessary for their care. Additionally, I sense that my patients feel empowered when they are given the opportunity to participate fully in the discussion of their care. Since utilizing the Teach-Back method, I have not only become a more effective practitioner, but have also seen an improvement in my patient satisfaction scores.”

Researchers analyzed data from about **33,000 patients** in Minnesota and found that the average health care costs of those with the highest levels of motivation, knowledge, skills and confidence to manage their own health care were

8-21% lower

than those with the lowest levels of motivation.

– Health News. © 2013 HealthDay.

How Did You TEACH BACK Today?

Clinician Presents New Concept:

- Health information
- Advice
- Instructions
- Change in management

End Results:

- Patient understanding
- Patient adherence
- Error reduction

Clinician explains/demonstrates new concept.

Clinician assesses patient recall and comprehension. Patient is asked to demonstrate understanding.

Clinician clarifies and tailors explanation.

Patient recalls, comprehends and demonstrates mastery of concept.

Clinician re-assesses patient recall and comprehension. Patient is again asked to demonstrate understanding.



Project BOOST Team. The Society of Hospital Medicine Care Transitions Implementation Guide: Project BOOST (Better Outcomes by Optimizing Safe Transitions). Society of Hospital Medicine website, Care Transitions Quality Improvement Resource Room, www.hospitalmedicine.org.



New Implantable Defibrillator Reduces Complications

GUEST AUTHOR

Dr. Asim Yunus, Electrophysiologist, Michigan CardioVascular Institute (MCVI)

Recent estimates show that approximately 850,000 people in the United States are at risk of sudden cardiac arrest (SCA). Many of these patients undergo surgery for implantable cardioverter defibrillators (TV-ICDs) to shock their heart into starting up when they experience life-threatening arrhythmia. Such technologies place thin, insulated wires (leads) inside the heart. Over time, however, these leads could grow into the chest veins and heart walls or become involved with infection and other problems. Removing these leads requires the use of hot lasers in the chest.

New subcutaneous (S-ICD) technology, however, overcomes those challenges, offering all the benefits of ICDs at a lower risk.

A New Category of Protection

Since S-ICDs are implanted under the skin, they avoid the need for any hardware to be placed into the chest itself, leaving the heart and vasculature untouched. Consequently, cardiac complications from implantation are significantly reduced.

S-ICD technology is simple too, containing just two components:

- The pulse generator placed at the side of the chest, which powers the device and monitors/shocks the heart as necessary.
- The electrode placed next to the breastbone to sense cardiac rhythm abnormalities and provide a pathway for delivering the shock.

While the S-ICD is larger than traditional ICDs, it is implanted in a more tolerant position (mid-lateral), does not interfere with arm movement and avoids large scars on the chest (see the post-operative photos below). Therefore, it is well-accepted by patients.



One month post-operative views for S-ICD shows minimal scarring.



~850,000
people in the U.S. are at
risk of sudden
cardiac arrest



Patient Screening and Recovery

Three groups of patients can benefit from the S-ICD system.

- Young people with arrhythmias.
- Those prone to recurring cardiac infections including those with diabetes and kidney diseases.
- Patients with limited vascular access such as dialysis patients.

S-ICD is appropriate for both primary and secondary prevention patients. Every patient undergoes a pre-operative screening and is evaluated for the device before the procedure.

The length of the surgery, length of hospital stay, frequency of follow-up visits and lifespan of the device are similar to traditional ICDs, as is insurance coverage.

Growing Acceptance

The U.S. Food and Drug Administration granted regulatory approval for the S-ICD System in September 2012. To date, more than 2,000 devices have been implanted in patients around the world with three devices implanted to date at Covenant HealthCare, one of the first institutions in the U.S. to apply this new technology.

Cumulative data for the S-ICD spans four years, contributing to a growing body of positive clinical evidence supporting its safety and efficacy. S-ICDs are an excellent example of advanced solutions that minimize invasiveness and maximize quality of life, and should be considered for patients at risk of SCA who meet the screening criteria.

For more information, contact Dr. Yunus at 989.754.3000 or ayunus@mcvi.com.



5 MINUTE SURVEY

PLEASE GIVE US YOUR OPINION

The Covenant Chart is entering its fifth year of publication. There is ALWAYS room for improvement, however, and we want to excel at meeting your changing needs for news and information. To achieve that, we need to hear from YOU, our readers, about how to make *The Covenant Chart* a better tool.

Please take 5 minutes to complete the survey below and send it back by July 15 in the enclosed Business Reply Mail envelope. We'll also send you this survey by email for added convenience.

1. Do you read *The Covenant Chart*? Yes No Occasionally

If you answered no, please explain why: _____

2. *The Covenant Chart* provides information of value: Agree Disagree

If you answered disagree, please explain why: _____

3. Please indicate your top 5 topics of interest (check those that apply):

- | | |
|--|--|
| <input type="checkbox"/> Disease updates, trends and alerts | <input type="checkbox"/> Electronic medical records/tools updates |
| <input type="checkbox"/> New medical technologies and treatments | <input type="checkbox"/> HIPPA and other regulatory updates |
| <input type="checkbox"/> Quality and safety initiatives | <input type="checkbox"/> Insurance coverage news/trends |
| <input type="checkbox"/> Improving physician leadership skills | <input type="checkbox"/> CMU residency program |
| <input type="checkbox"/> Improving physician clinical skills | <input type="checkbox"/> Improving patient satisfaction/outcomes |
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| <input type="checkbox"/> Nursing staff updates | <input type="checkbox"/> Covenant HealthCare performance / certifications / awards |
| <input type="checkbox"/> Other: _____ | |

4. I prefer the following format: Printed format sent by U.S. mail Electronic pdf sent by email

5. I prefer the following frequency and length: Quarterly with about 8-10 articles per issue (the current approach)

Once / month with 2-3 articles per issue (more frequent but fewer)

Other _____

6) Do you have other ideas or suggestions for *The Covenant Chart*? _____

SIGN UP AND GET INVOLVED

If you currently receive the printed version of *The Covenant Chart* by U.S. mail, and would like to receive it by email instead, please contact Maryvonne DeSmyter at **989.583.4040** or mdesmyter@chs-mi.com.

Meanwhile, we welcome more authors and are more than ready to help you draft an article! If you are interested, please contact:

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ICD-10 Implementation Date Delayed

*Dr. Michael Sullivan
Chief Medical Quality and Informatics Officer*

In the last issue of *The Covenant Chart*, you received an update on Covenant's ICD-10* implementation plan. This plan was based on the mandated rollout of ICD-10 on October 1, 2014. However, the recent passing of the "Protecting Access to Medicare Act of 2014" changed the ICD-10 implementation date – to not before October 1, 2015.

The new, yet ambiguous, start date for ICD-10 forced a reassessment of the project plan. It has been decided that Covenant HealthCare will stay the course, taking advantage of the delay to improve our preparedness for ICD-10. Coders and clinical documentation specialists will complete all required education and begin dual coding a subset of their work in an effort to identify additional documentation needs for service lines and physicians.

In an effort to provide timely physician education, we have decided to push back our physician education plans to a time closer to ICD-10 implementation. Stay tuned for the revised kickoff dates and more details concerning education tools and materials.

For more information, contact Dr. Sullivan at 989.583.7351 or msullivan@chs-mi.com.



*International Classification of Diseases Tenth Revision



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