THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | DECEMBER 2017

Creating a Culture of Wellness

Dr. Michael Fiore
Covenant HealthCare Chief of Staff

In this edition of *The Covenant Chart,* we acknowledge the transition of our physician leadership team. Two longstanding physician leaders, Drs. John Kosanovich and Michael Schultz, are retiring in December and January, respectively. I encourage you to read their letters on pages 6 and 10, each providing very powerful advice for physician leaders. Both individuals are dedicated and committed physicians who can serve as role models for future leaders. They have helped establish a cultural foundation, bridging the gap between administration and physicians. We wish them well in their retirement!

We often focus on the safety, quality, and efficiency of patient care. Central to these core values are highly functioning physicians. Despite this knowledge, there is amassing data reflecting the increasing prevalence of physician burnout and disengagement. There are many complex drivers of physician burnout, some of which are institutional or governmental. These include loss of physician autonomy, increased productivity demands, and a growing and increasing array of imperfect quality metrics that can lead to a decline in professional fulfillment.

While we work with each other to achieve an organizational culture of patient safety and quality, we also need to encourage a culture of *wellness.* There are numerous strategies to improve personal wellness. Obvious examples include achieving optimal nutrition, exercise, and sleep. If we encourage and expect wellness in our patients, then we certainly deserve to provide it for ourselves. We are all keenly aware of the beneficial effects on improved health and wellness, such as improved cognitive performance, increased work and personal satisfaction, and stress reduction. Healthy physicians are more likely to encourage positive health behaviors in our patients as well as our colleagues.

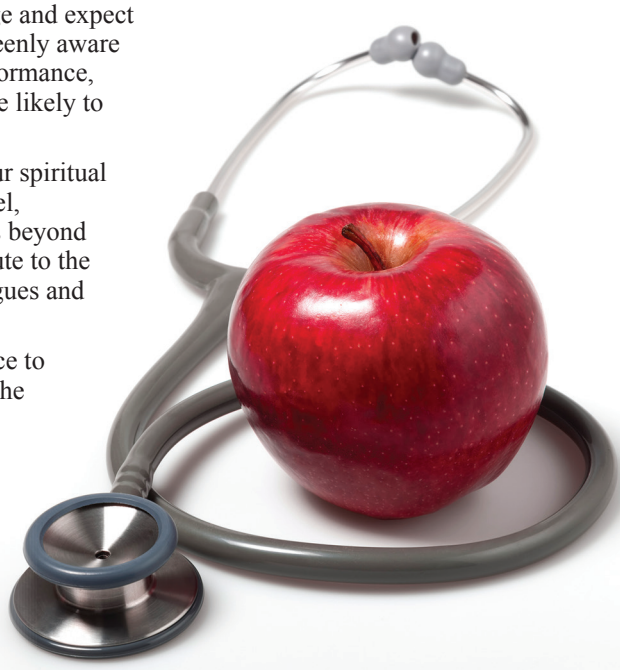
Wellness does not need to be limited to diet and exercise. We also need to be mindful of our spiritual wellness – in whatever manner you find meaningful. This may be religion, music, art, travel, connection with nature, or other avenues of personal growth. A culture of wellness extends beyond individual needs. As your personal well-being improves, you will be able to better contribute to the organization's culture of wellness by encouraging positive health behaviors in your colleagues and healthier inter-professional interactions.

Historical medical training has acculturated physicians to deny self-care and provide service to others. We owe it to ourselves, our patients, and future generations of physicians to break the myth that patient care and self-care are competing interests.

Sincerely,

Dr. Michael Fiore
Chief of Staff

While we work with each other to achieve an organizational culture of patient safety and quality, we also need to encourage a culture of wellness.



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The Growing Demand for Virtual Visits: Are You Prepared?

GUEST AUTHOR
Jaime TerBush, Program Administrator, Covenant VirtualCare

The Trends and Impact

The rise of mobile and online communications via Smart phones, tablets, laptops, video, texting or tweeting shows no sign of abating. If anything, the convenience and connectivity they afford have only fed a growing hunger among consumers across industries for applications that save time and reduce costs while making life easier.

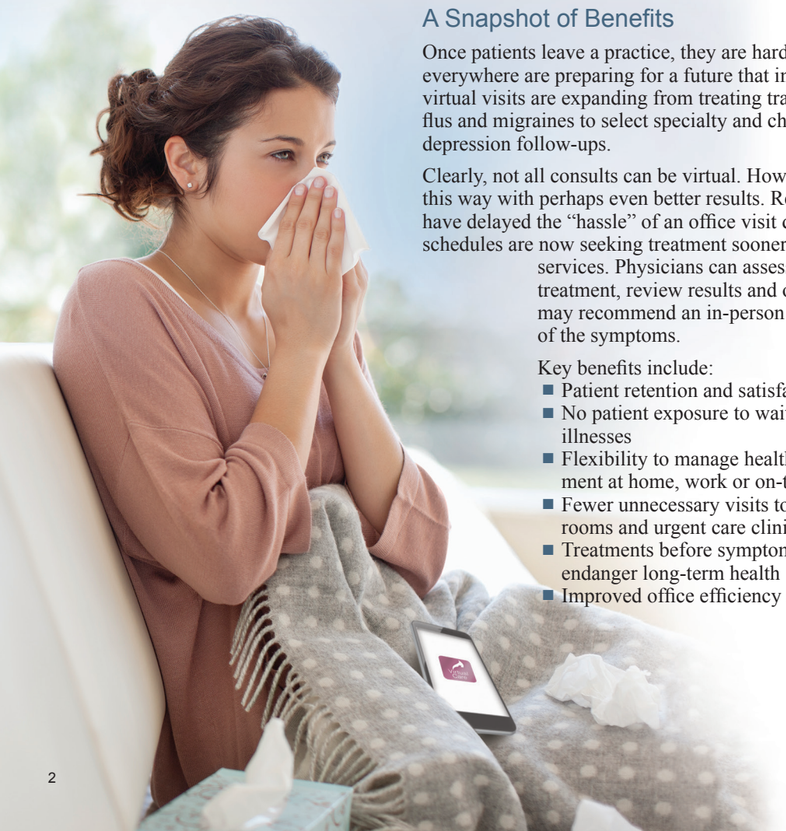
The impact on the healthcare industry alone is huge as telehealth services take hold, including the virtual office visit. In today's world, physicians have a unique opportunity to be more patient-centric, taking the visit to the patient instead of requiring the patient to come to them – and to achieve this safely, securely, swiftly and effectively.

According to a 2017 American Well® consumer survey involving more than 4,000 adults:

- 79% of those caring for a relative would find video visits very helpful.
- 60% would like to see a doctor online to manage a chronic condition.
- 52% are open to video visits for post-surgical follow-ups or hospital discharges.
- 20% would switch physicians just to have a virtual visit capability.

Many other surveys make similar conclusions that consumers are more than ready for virtual healthcare visits, even switching providers to get them. For example, an Advisory Board survey shows that 77% of respondents would consider seeing a provider virtually, and 19% already had (see Telehealth Resources sidebar for details).

Consequently, traditional brick-and-mortar offices should be supplemented with other care options – not only due to increasing demand for virtual visits, but also in light of growing competition from retail clinics and virtual urgent care services.



A Snapshot of Benefits

Once patients leave a practice, they are hard to get back. Recognizing this, physicians everywhere are preparing for a future that includes virtual office visits. Already, virtual visits are expanding from treating traditional urgent care needs such as colds, flus and migraines to select specialty and chronic care visits too, such as anxiety and depression follow-ups.

Clearly, not all consults can be virtual. However, many situations can be handled this way with perhaps even better results. Research shows that people who may have delayed the "hassle" of an office visit due to distance, procrastination or busy schedules are now seeking treatment sooner due to the fast and easy access to online services. Physicians can assess symptoms, answer questions, discuss treatment, review results and order prescriptions. In some cases, they may recommend an in-person office visit too, depending on the severity of the symptoms.

Key benefits include:

- Patient retention and satisfaction
- No patient exposure to waiting room illnesses
- Flexibility to manage health and get treatment at home, work or on-the-go
- Fewer unnecessary visits to emergency rooms and urgent care clinics
- Treatments before symptoms worsen and endanger long-term health
- Improved office efficiency and productivity

USEFUL TELEHEALTH RESOURCES

WHAT	LINK
Telehealth Index: 2017 Consumer Survey, American Well® Report	http://go.americanwell.com/rs/335-QLG-882/images/American_Well_Telehealth_Index_2017_Consumer_Survey.pdf
Consumers Are Ready for Specialty Virtual Visits. Are You? Advisory Board Infographic	https://www.advisory.com/research/market-innovation-center/resources/posters/are-you-ready-for-specialty-virtual-visits#.WS8g8bR7wyc.email
Shopping the System: Consumers Find Value In Virtual Care, Zipnosis Report	http://www.zipnosis.com/assets/shopping-the-system.pdf
Five Reasons Virtual Doctor Visits Might Be Better Than In-Person Ones, Mobihealth News Article	http://www.mobihealthnews.com/22215/five-reasons-virtual-doctor-visits-might-be-better-than-in-person-ones
Covenant VirtualCare, Website	http://www.covenanthealthcare.com/main/virtualcare.aspx

Strategies to Enable Online Care

Healthcare organizations nationwide are taking steps to enable virtual office visits, viewing it as essential to competitive advantage. Kaiser Permanente, a progressive hospital in California, is a case in point, stating that more than half of its patient visits are now done virtually versus an in-person visit.

Covenant HealthCare is another case in point, leading the Great Lakes Bay Region as the first hospital to offer a virtual visit application. Its program, named Covenant VirtualCare, uses technology to enable virtual medical consultations via desktop computer, tablet or smart phone. Patients can enroll online or download the app.

At Covenant, three basic strategies are being employed to deliver VirtualCare services:

1) Provide training to interested Covenant Medical Group (CMG) physicians to use VirtualCare services in their offices.
2) Contract with members of the Physician Hospital Organization (PHO) interested in using the VirtualCare platform to complement their office services with scheduled virtual visits.
3) Fully integrate the VirtualCare platform and Epic to ensure continuity of care, accuracy and safety.

COVENANT VirtualCare

The first physician training at Covenant occurred in January 2017 for physicians who wanted to be early VirtualCare adapters. As of December, the program has grown to include nine primary care physicians and seven specialists trained to provide scheduled virtual office visits. The entire process – from planning to implementation – typically takes 30 to 60 days, depending on the size of the practice.

Note that some barriers to reimbursement are being experienced as insurance companies are still on a learning curve too, and not accustomed to direct-to-consumer claims. While they will pay, they are still uncertain about paying the same amount for a virtual visit as for an in-office visit. We are optimistic that these issues will be resolved soon, especially as payers realize the benefits to them as well.

Summary

Virtual office visits allow physicians to provide patients with convenient access to medical care, while potentially improving patient health and outcomes. Physicians become even more responsive and competitive, while patients become more empowered and engaged in their health.

Change is never easy but it's important to stay ahead of the curve because virtual visits are here to stay and are becoming a way of life. Together, we have the opportunity to use extraordinary technology to deliver extraordinary care to all our patients.

For more information or to initiate training, contact Jaime TerBush at 989.583.4363 or jaimeterbush@chs-mi.com.

Urinary Incontinence: Update on Neurogenic Bladder

GUEST AUTHORS
Dr. Babu Nahata, Physiatrist, Covenant Physical Medicine & Rehabilitation, and
Cathy Campbell, Clinical Outcomes Nurse Specialist, MS, RN, CRRN

Urinary incontinence is a major health problem with women experiencing it twice as often as men due to pregnancy, childbirth, menopause and the structure of the female urinary tract. It is difficult to accurately determine how many people have incontinence because people are often not honest about this potentially embarrassing condition, but estimates are that about 10 million adult Americans and approximately 15-30% of the elderly are incontinent.

Urinary incontinence can be caused by many factors, including detrusor instability, urinary tract infection (UTI) or inflammation, sphincter incompetence, loss of sensation, neurogenic bladder or simply the inability to get to a bathroom. The focus of this article is on **neurogenic bladder** as a cause of incontinence and possible treatment options for physicians to consider.

Neurogenic bladder is caused by a disruption in the innervation of the bladder, bladder neck or external urinary sphincter from the brain, spinal cord or peripheral nerves. A neurogenic bladder may be the cause of urge incontinence, functional incontinence, reflex incontinence or overflow incontinence. All have varying treatment options.

Types of Incontinence and Treatments

Urge incontinence is often seen after brain injury, stroke, multiple sclerosis, Parkinson's disease or brain tumors. It is characterized by frequent, small voids, normal bladder sensation and complete bladder emptying. The patient has volitional control of voiding, but often cannot make it to a toilet. This is probably the most common form of neurogenic bladder.

- A post-void residual (PVR) bladder scan must be done to determine if the patient is emptying their bladder (ideally less than 200 cc), and a urinalysis/culture and sensitivity (UA/C&S) should be performed to rule out UTI which has similar symptoms.
- Once both are ruled out, regular fluid intake, not surpassing 2000 cc/day, and a timed voiding schedule are often successful at achieving continence.
- If they are not successful, a bladder antispasmodic, like tolterodine may be prescribed to relax the bladder and increase the interval between voids.

Functional incontinence is caused by brain injuries, severe confusion and dementia. Immobility and environmental barriers, while not a neurogenic bladder, can also cause functional incontinence due to the patient's inability to get to a toilet.

- A PVR bladder scan should be done to rule out urinary retention along with a UA/C&S.
- After that, a 2000 cc fluid limit and a time-voiding schedule can be started.

Estimates are that about 10 million adult Americans and approximately 15-30% of the elderly are incontinent.

Reflex incontinence is seen after spinal cord injuries (traumatic and nontraumatic) or tumors, multiple sclerosis or transverse myelitis. The symptoms are spontaneous, small voids, little or no volitional control, little or no awareness of voiding or the need to void and moderate residuals.

- A PVR bladder scan is needed to assess bladder emptying and a UTI should be ruled out.
- An intermittent catheterization program is often needed, with the aim to keep bladder volumes less than 400 cc to avoid bladder stretching and micro-hemorrhages.
- Regularly spaced fluid intake, limited to 2000 cc/day, is very important if the patient has urinary retention for a successful intermittent catheterization program.
- "Trigger voiding" (tapping on the lower abdomen or pulling pubic hairs) can also sometimes initiate a reflex void. Males usually wear an external catheter and females a brief, due to the inability to control when they will urinate.
- In some cases, a female will opt to take a detrusor antispasmodic, like tolterodine, to paralyze the bladder and then do intermittent catheterization around the clock so that she is not incontinent.
- In the face of detrusor-sphincter dyssynergia, an alpha blocker like tamsulosin may need to be prescribed to relax the bladder neck, or a medication that relaxes the external sphincter like baclofen or Valium®, to allow for uninhibited flow of urine from the bladder. Detrusor-sphincter dyssynergia can only be diagnosed by urodynamic testing.

Overflow incontinence may be caused by a sacral spinal cord injury or lesion, pelvic nerve trauma or lesions, herniated disk, Guillain Barré syndrome, multiple sclerosis or diabetic neuropathy.

- A PVR bladder scan will immediately in form you that your patient is not completely emptying their bladder.
- Intermittent catheterization may be used, or the temporary insertion of an indwelling urinary catheter may be needed.
- At times, a medication that stimulates the bladder to contract, like bethanechol may be helpful (if mechanical obstruction has been ruled out). However, bethanechol should be used judiciously because it has many side effects, especially in the geriatric population.
- Tamsulosin may also be helpful if the patient has urinary retention.
- Note that before the catheter is removed for a voiding trial, the practice of "clamp and release" is no longer recommended. This has been shown by evidence to NOT be effective in building up bladder tone and preparing the bladder for voiding. The best practice is just to remove the catheter and start a voiding trial with PVR bladder scans and intermittent catheterization as needed to empty the bladder. If effective and spontaneous voiding does not return, the patient may be taught how to catheterize themselves using clean technique.

Bladder Training

Bladder training is another form of treatment. Because "bladder training" means different things to various practitioners, it is advised to NOT use this term to avoid confusion. Technically, it is a behavioral modification treatment technique for urinary incontinence that involves placing a patient on a toileting schedule. The time interval between urination is gradually increased to train the patient to remain continent. This type of training is best accomplished on an outpatient basis under the care of a urologist or urology nurse practitioner.

Key Physician Actions

For patients with incontinence:

- Obtain a PVR bladder scan to rule out urinary overflow in your patients with urinary incontinence.
- Obtain a UA/C&S to rule out UTI.
- Place the patient on a timed voiding schedule with limited fluid intake if no retention exists.

For patients with a Foley catheter due to urinary retention or incontinence:

- DO NOT order "clamp and release" before the catheter is disconnected.
- Place an order for the catheter to be discontinued and then start a voiding trial with PVR residuals until less than 200 cc.
- Start intermittent catheterization if needed, if PVR residuals are greater than 200 cc.

For patients with urinary retention:

- Rule out UTI.
- Start a timed-voiding schedule with PVR residuals until less than 200 cc.
- Start intermittent catheterization if needed, or reinsert catheter.
- Consult a urologist if retention continues.

Urinary incontinence is distressing and can significantly affect quality of life, but fortunately, there are many treatments that deliver positive outcomes. Physicians should obtain a urology consult for all patients who do not respond to basic treatment options.

For more information, contact Cathy Campbell at 989.583.2762 (ccampbell@chs-mi.com) or Dr. Nahata at 989.583.2862 (bnahata@chs-mi.com).

CMU Fifth Class Dons White Coats

The Central Michigan University (CMU) College of Medicine Class of 2021 donned their clinical white coats for the first time on August 4 during the College of Medicine's 5th White Coat Ceremony. Seen as a symbol of authority and professionalism, the white coat signifies the beginning of a student's journey toward becoming a physician.

The CMU College of Medicine seeks to admit students who are academically qualified and have interests that align with its mission to prepare diverse, culturally competent physicians who are focused on improving access to high-quality healthcare in Michigan, with an emphasis on rural and medically-underserved regions.

The fifth class represents the mission very well, with 5,443 applications and 423 campus interviews, resulting in 104 students accepted to the college – 78% of whom are Michigan residents. Additional statistics include:

- The states with the largest number of non-resident students in the fifth class are California, Florida and Texas.
- The top four institutions from which students in this class graduated are the University of Michigan, Michigan State University, Wayne State University and Central Michigan University (in that order).
- The fifth class includes 50 men and 54 women, with 13% from populations that are considered to be under-represented in medicine.
- To date, a total of 480 students across all five classes have been admitted.

The White Coat Ceremony's keynote speaker was Catherine Baase, MD, FAAFP, FACOEM, former Chief Health Officer & Global Director of Health Services for The Dow Chemical Company.

Dr. Baase pointed out during her remarks that the significance of the white coat ceremony is the symbolism of the conversion of the layperson into the health professional, and that the white coat visually conveys the sacredness of being a physician.

The first two years of each new class is spent on CMU's main campus in Mount Pleasant in a dedicated 60,000-square-foot facility. The following two years are spent at the new 46,000-square-foot College of Medicine educational facility in Saginaw and in clerkships across the state – including hospital clerkships at Covenant HealthCare and St. Mary's of Michigan.

Currently, 198 students from the CMU College of Medicine are engaged in these clerkships, with about 180 rotating at healthcare institutions in the Saginaw area.

A Pleasure and an Honor

A Letter from Dr. Michael L. Schultz, Vice President of Medical Affairs / Chief Medical Officer

Being a part of Saginaw's medical community since 1982 when I began my residency in Family Medicine has been nothing short of a pleasure and an honor. After years of treating patients in private practice, I transitioned to Administration at Covenant HealthCare in 2008, taking a newly developed role called the Chief Medical Quality and Informatics Officer. Then in 2012, I became the third Vice President of Medical Affairs, from which I will be retiring in January 2018.

You can't walk away from that experience without some nuggets of wisdom, which I want to share with all of you. There are many ways to look at leadership, but what always puts me in the 'leadership zone' are what I call the "four pearls of leadership." When applied together, I have found that these pearls can significantly boost teamwork, results and success.

PEARL #1. **Look in the mirror – be directed from within.**

Integrity is the quality of being honest and morally upright. Integrity increases by matching your actions to your values. Whatever the situation, to be effective at leading a cause, there must be compatibility with your values. I have chosen to adopt High Reliability principles as four personal values to help guide my actions. These include Situational Awareness, Sensitivity to front line operations, Resilience, and Deference to expertise. Adopting these as personal values, and then reconciling my intentions with those values and being directed by them, provides a strong platform for leading change successfully.

PEARL #2. **Prepare – develop a purpose.**

Having a clear purpose that can be described articulately ensures that your direction and efforts will be heard and respected, and not go astray. To have a clear purpose, there must be a deep understanding of the need for action. Beginning with the end in mind will help develop the proper purpose for any change being considered or for any conflict being addressed. Being purpose-centered in your approach will help portray and reinforce the necessary vision to lead others in a direction they might not otherwise choose or consistently support.

PEARL #3. **Seek understanding – know the other person.**

We have all heard the adage about walking a mile in someone else's shoes. I have learned that the better I understand the other person, the better I can deal with conflict. A favorite quote from one of my favorite books (Ender's Game by Orson Scott Card) is when Ender Wiggin says, "In the moment when I truly understand my enemy, understand him well enough to defeat him, then in that very moment I also love him." That statement may be a bit extreme, but it makes an important point: Seeking a deeper understanding of other people allows us to see their humanity. Understanding their views and interests is also a well-tested principle of negotiation and certainly applies to leading people.

PEARL #4. **Listen – be externally aware.**

Listening seems so easy and I suspect most of us believe we are good listeners. Listening is a prerequisite to avoiding tunnel vision and potentially missing what might be the best solution to a thorny problem. When speaking about the importance of listening, a wise pastor once admonished his congregation to, "Never miss an opportunity to keep your mouth shut!" Those are true words of wisdom that have served me well. After all, as soon as we begin talking we stop learning. Leading change effectively includes being aware of changes in the environment, which can only be achieved by careful listening.

Even when motivation is low, engaging those four pearls of leadership can help everyone gain the initiative and energy to work together for meaningful change that benefits us all: medicine, patients, healthcare professionals, healthcare institutions, the communities we serve, and our families and friends.

Looking around, I deeply believe that Covenant HealthCare is a premier institution served by premier people with a special calling to heal others in need. I am honored and privileged to call you my colleagues and friends, and wish you every success in the future.

Michael L. Schultz, MD

Four Pearls of Wisdom

1. *Look in the mirror – be directed from within.*
2. *Prepare – develop a purpose.*
3. *Seek understanding – know the other person.*
4. *Listen – be externally aware.*

THE CHART SPOTLIGHTS

Congratulations Physicians of the Month!

Your patients are saying extraordinary things…

SEPTEMBER

Dr. Peter Walsh

"Dr. Walsh is an excellent doctor who listens to your concerns."

"Dr. Walsh was very professional and explained everything."

"Dr. Walsh was very kind."

OCTOBER

Dr. Mark Ginther

"I feel Dr. Ginther is one of the best doctors I have ever had."

"Dr. Ginther is patient and listens to what I have to say."

"I am very fortunate to have him (Dr. Ginther) as my doctor."

NOVEMBER

Dr. Augusta Uwaje

"Dr. Uwaje makes me feel special; she answers all my questions."

"She is very nice and kind to me."

"She makes me feel great while checking my health."

DECEMBER

Dr. Catherine Champagne

"Dr. Champagne is super-nice and respectful."

"She treated me until I got better and over my abdominal pain; she is a life saver."

"I enjoyed the way she entered the room with a huge smile."

Preventing Falls with AvaSys® Virtual Monitor

GUEST AUTHOR
Frank Fear, Chief Information Officer, Covenant HealthCare Information Technology

Each year, up to one million people in the United States fall in the hospital, causing insurers like Medicare to hold hospitals accountable for the increased costs due to a fall, and driving hospitals to implement technologies that increase safety and prevent falls. One such technology is the AvaSys® Virtual Monitoring System, which is helping hospitals nationwide drive results.

Each year, up to *one million* people in the United States fall in the hospital.

The Impact of Falls

A fall may result in bruises, fractures, breaks, cuts or internal bleeding. Falls are associated with increased length of stay, higher rates of discharge to nursing homes, and the need for more healthcare resources – not to mention more pain and stress for the patient.

Falls are the most frequently reported incident in adult inpatient units. A few interesting statistics include:

- The rate of falls ranges from 1.7 to 25 falls per 1,000 patient days depending on the unit, with geriatric psychiatry patients having the highest risk.
- About 30-51% of falls in hospitals result in some sort of injury.
- One study found that operational costs for fallers experiencing serious injury were $13,316 higher than for non-fallers.
- Medicare actually stop reimbursing hospitals in 2008 for costs related to an in-hospital fall.

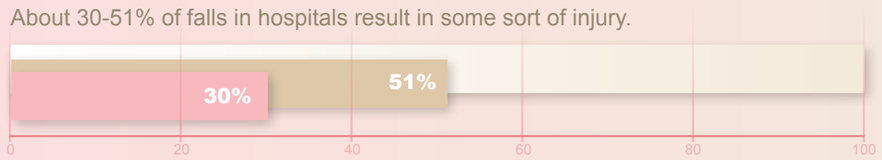
How AvaSys® Virtual Monitoring Helps

Research shows that close to one-third of hospital falls can be prevented. Fall prevention involves managing a patient's fall-risk factors and optimizing the environment. It also means implementing leading-edge technologies like the AvaSys Virtual Monitoring System, which provides a high-tech yet cost-effective opportunity to observe patients in real time.

With AvaSys Virtual Monitoring, a video camera and two-way audio system in a patient's room transmit real-time data to a central monitoring station. This allows a trained observer to remotely monitor multiple at-risk patients at the same time, interact with the patient immediately via a pillow speaker, and alert nurses to intervene as necessary before an incident occurs. Note: At no time does the system record audio or video.

The same technology can be used to observe patients in holding areas, prevent them from pulling IVs or wandering off, and to protect staff from violence.

Covenant HealthCare piloted AvaSys Virtual Monitoring last spring with the Physical Medicine & Rehabilitation department's Rehab Unit, as part of its continuing "We Care Connect" initiative to improve patient safety and quality. Since then, the Rehab Unit has experienced a dramatic reduction in falls. Over the summer months, it achieved 50 days without a fall – the first time since February 2013. In addition, it has experienced over a 65% reduction in physical patient sitter hours. This success was followed by a broader launch in October on Cooper 4 North, Harrison 6 Main and Harrison 3 South.



Virtual AvaSys® Monitoring device.

Program Goals and Value

AvaSys Virtual Monitoring – along with other initiatives such as "Call Don't Fall" and our physical "Patient Sitter program" – perfectly aligns to the Covenant strategy for patient-centric care, quality, safety and cost-effectiveness.

Program goals and measures of success include:

- 35% reduction in unassisted falls on nursing units where AvaSys Virtual Monitoring is used
- Stretch target of zero falls during a one-month period for patients supervised virtually
- 5% reduction in falls with injury
- 50-60% reduction in physical sitter hours on nursing units where AvaSys Virtual Monitoring is used
- All AvaSys Virtual Monitoring units are in use greater than 90% of time

While it does not eliminate the physical patient sitter program (e.g. suicidal patients), AvaSys Virtual Monitoring does provide the ability to monitor a greater percentage of fall-risk patients and to do so more cost-effectively than adding more physical sitter resources. By implementing this program, Covenant can provide over 262,000 hours of patient monitoring per year versus just 18,000 hours using physical sitters. This allows Covenant to monitor more at-risk patients without extra concerns about rounding.

AvaSys Virtual Monitoring can further reduce expenses by freeing staff time for other activities and streamlining scheduling.

Your Role

Thomas Edison once said, "Genius is 2% inspiration and 98% perspiration." In other words, coming up with the idea for a new technology is actually easier than implementing it. Success takes teamwork, observation, communication and continuous improvement.

Physicians, in particular, can play an important role by informing the nursing staff, in advance, if a patient is a high-fall risk and could benefit from AvaSys Virtual Monitoring. If you feel your patient needs special attention, please remember to speak up!

For more information, contact Frank Fear at 989.583.0224 or ffear@chs-mi.com.

The rate of falls at hospitals nationwide range from 1.7 to 25 falls per 1,000 patient days depending on the unit, with geriatric psychiatry patients having the highest risk.

Parting Reflections

A Letter from Dr. John Kosanovich, Enterprise, and CEO, Covenant Medical Group

I have been extremely fortunate over the last 34 years to have had two careers that I thoroughly enjoyed, yet at one time, they were considered to be at different ends of the spectrum. The first career was as a clinician practicing nephrology. This was followed years later with a career as a hospital administrator.

On the executive team, I was initially a Chief Medical Officer (CMO) bridging that old chasm between physicians and administration. It is a fascinating position to be in, for you are the only one who has the unique perspective of the challenges that physicians face in trying to care for their patients, while at the same time appreciating what hospital administrators face in trying to keep the organization running.

Thanks to healthcare reform, that dichotomy no longer exists – not that there aren't those on either side who haven't appreciated this yet. Challenges that physicians and hospitals face are now mutual. Survival will depend upon both sides working together for the same goal: cost containment while providing quality care. Enter ACOs, CINs, bundled payments and the like.

Whether the issues I have faced were physician- or hospital-generated, there are three "rules" of success that have helped me over the years that might help you too:

First: Never take it personally. There are many who are not capable of entering into a debate or even an argument without being condescending. Taking what is said personally only adds to one's stress and diminishes your effectiveness in getting to a resolution.

Second: Always assume positive intent. This is baked into our recent physician compact but it is something I have lived by for years. Ultimately everyone wants what is right for the patient and the organization. Give people the benefit of the doubt and approach issues from this perspective.

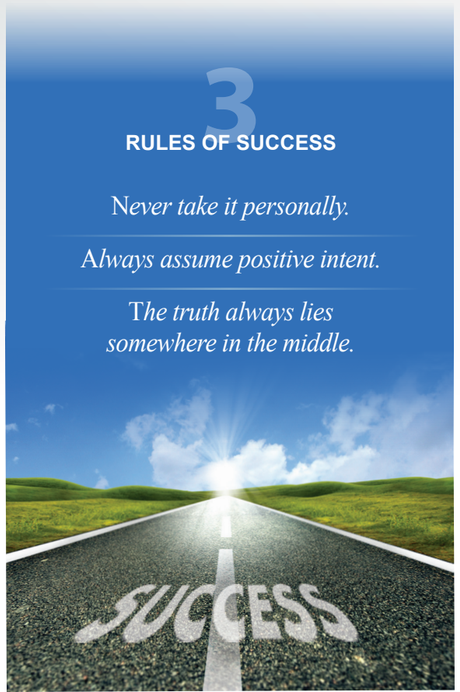
And last: The truth always lies somewhere in the middle. Everyone can't be right but everyone has the right to voice an opinion. Sometimes the debate or argument is intense with passions raging on both sides. I try to stay focused on the middle ground, for it is middle ground upon which resolution is generally built.

These three rules have allowed me to navigate through the most difficult of conflicts, and I apply them in my personal life too.

Looking forward, as my administrative medicine career winds down, I firmly believe that our physicians must become even more involved in the business side of medicine. Physicians and administrators need to continue to work together in facing the challenges that healthcare reform will throw at us and, as they do, both sides should always remember those three rules. They are proven to make the path easier and the results better.

Thanks for the opportunity to work with all of you at Covenant HealthCare. You are a great team and I know this institution is in very good hands.

John M. Kosanovich MD



Guidelines for Mammograms for Over 70

GUEST AUTHOR
Dr. Joseph Contino, Breast Surgeon
Covenant Cancer Care Center

Many women over age 70 are not getting routine screening mammograms due to the misperception that patients in this age group don't benefit from screening mammograghy.

According to an October 2015 position statement from the American Society of Breast Surgeons (ASBrS), routine screens should still be performed for this age group to decrease morbidity when cancers are found early.

While a screening mammography may not show a big impact on survival curves, it can greatly improve quality and length of life. Note that:

- Patients are living longer due to advanced treatments for chronic medical conditions.
- The projected increase in breast cancer diagnosis is expected to rise by 36% by the year 2030.

Therefore, mammography should be discussed with individual patients using *less* of an age-based framework and *more* of a physiologic or risk-based framework.

Guidelines Overview

The United States Preventive Services Task Force (USPSTF) recommendations in 2009 were made based on old imaging and treatment data. Those guidelines recommended biennial screening for women ages 50-74 and said there was insufficient evidence to support screening women over age 75, as the trials did not include women older than 74.

The American Cancer Society (ACS), however, does indeed recommend continued screening. Various meta-analyses on at least eight mammography trials to assess its effectiveness in reducing breast cancer mortality have pointed to the value of mammograms for all age groups, but with a greater benefit for women over age 50. When an Age trial from the United Kingdom was added, they found an even larger benefit for women over 60 with a 15% reduction in mortality.

Consequently, the ACS published new guidelines in 2015, recommending biennial screening for women over age 55, and to continue screening if they have an estimated 10-year life expectancy.

According to the guidelines, 26% of breast cancer deaths are in women over age 75 and yet 50% of women over 80 are expected to live another 10 years.

Since the data strongly point to the benefits of mammograms over age 70, physicians and patients should collaborate to make individualized decisions for mammography. Evidence shows it can enhance longevity and quality of life. Please see the sidebar for general ASBrS recommendations.

For more information, contact Dr. Joseph Contino at 989.583.5060 or joseph.contino@chs-mi.com.

ASBrS Recommendations

Asymptomatic Average-Risk Women

- Discuss screening mammography with women ages 40-44, based on risk-benefit discussion.
- Suggest annual screening for women ages 45-54.
- Suggest annual or biennial screening for women age 55 and older based on risk-benefit discussion.
- Suggest biennial screening for women over age 75 if estimated life expectancy is greater than 10 years.
- Consider breast tomography to increase detection rates and decrease false positive rates.

Asymptomatic Intermediate-Risk Women

- Consider risk assessment tool to determine estimated lifetime risk for breast cancer.
- Consider use of annual screening mammography for women with greater than an estimated 15% lifetime risk or recommend entry into clinical trials evaluating risk-based screening.

High-Risk Women
(20-25% or greater lifetime risk)

- Discuss risk assessment tool to determine estimated lifetime risk for breast cancer and risk of germline mutation predisposing to cancer.
- Discuss annual screening with mammography and breast-MRI, ensuring compliance with ACS and National Comprehensive Cancer Network (NCCN) Guidelines.

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