OHNS Spotlight

October 2024

HENRY FORD HEALTH®

In this issue:

The Impact of Sialendoscopy on the Management of Non-Neoplastic Benign Salivary Gland Diseases and the Preservation of Major Salivary Glands

Historically, minimally invasive treatment options for benign salivary gland disorders that prioritize the preservation of major salivary glands have been extremely limited. This paradigm shifted in 2004 with the introduction of diagnostic and therapeutic sialendoscopy in the United States. This innovative procedure offers a minimally invasive surgical alternative for managing a range of non-neoplastic salivary gland diseases, including salivary stones, strictures, radioactive-iodine-induced chronic sialadenitis, juvenile recurrent parotitis, eosinophilic sialodochitis, and autoimmune conditions such as Sjögren's syndrome. The advent of sialendoscopy has provided a significant alternative to traditional open surgical procedures that involve the partial or total removal of the major salivary glands.

Procedure overview

Sialendoscopy is typically performed in an operating room setting using specially designed sialendoscopes that range in diameter from 0.8 to 1.6 millimeters. This procedure allows for the simultaneous diagnosis and management of obstructive salivary duct pathology. The working channels of the larger sialendoscopes facilitate the removal of salivary stones and mucous plugs, balloon dilation of ductal strictures, biopsy of intraductal polyps or masses, and the direct delivery of steroids or antibiotics to the major salivary ducts and glands. Additional salivary gland-sparing techniques, such as endoscopic laser lithotripsy or combined endoscopic-transoral and endoscopic-transcervical approaches, are often effective for larger (>6 mm) salivary stones. This approach effectively addresses clinical symptoms while preserving salivary gland function.

Bringing sialendoscopy to Henry Ford Health and beyond

Despite its introduction nearly two decades ago, sialendoscopy remains not widely available in the United States. The procedure demands specialized surgical training, which is not universally provided in Otolaryngology residency programs, and relies on fragile and expensive sialendoscopes that many hospital systems cannot afford. Additionally, insurance coverage for this procedure remains inconsistent, I was fortunate to acquire training in sialendoscopy during my Otolaryngology-Head and Neck Surgery residency at Boston University. Since joining Henry Ford Health in 2017, we have successfully introduced advanced sialendoscopy procedures at both Henry Ford West Bloomfield and Henry Ford Macomb Hospitals. The success of this procedure extends beyond surgical expertise; it requires a collaborative approach involving anesthesiologists, interventional radiologists, and specialized equipment. Henry Ford Health is distinguished in the region for its streamlined processes and comprehensive resources, establishing it as a leader in delivering this gland-preserving procedure. Additionally, I have had the privilege of serving as faculty for several national and international sialendoscopy courses, including the 5th Annual Jefferson Sialendoscopy Course in Philadelphia, PA, the 2023 Harvard Sialendoscopy Symposium in Boston, MA, and the 3rd International Sialendoscopy Conference in Geneva, Switzerland.

Benefits and future prospects

Despite the challenges, providing this advanced treatment for our patients is profoundly rewarding. Patients who previously faced limited options, such as continued suffering or gland removal, can now benefit from a minimally invasive procedure that preserves salivary gland function. As the indications for sialendoscopy evolve, our multidisciplinary team at Henry Ford Health remains committed to offering qualified candidates a valuable alternative to salivary gland removal that improves patient outcomes and enhances quality of life.

Christie Morgan, M.D. is a senior staff surgeon, Department of Otolaryngology-Head and Neck Surgery and director, GME Patient Safety / Quality Improvement at Henry Ford Health.

Developing Best Practice Model Through ENT Pluralistic Model of Care with Employed and Non-Employed Physicians

As a sub-specialist in rhinology and skull-based surgery at Henry Ford Health, I've had the pleasure of being part of a major health system ranked consistently for top level care. My expertise spans common issues like nasal obstruction and chronic sinusitis, to advanced care for complex revision sinus cases or skull-based tumors where we work with neurosurgery or ophthalmology colleagues. Our ENT physicians through Henry Ford Health (HFH) see more than 68,000 outpatients and perform more than 3,500 head and neck surgeries yearly. Our work has continued to grow in recent years with more than two dozen otolaryngologists and services provided at five Henry Ford Health hospitals and eight outpatient clinics.

Recently I became site lead for our ENT physician group at Henry Ford Macomb Hospital, our second largest/busiest hospital system in the HFH network. At this site, our Medical Group physicians jointly share patients, hospital privileges and resources with the local private practice physicians, underscoring the community integration of this hospital. Because both physician groups (those "employed" by the HFH medical system versus those in private practice i.e., "non-employed") have different ways of running their operating models, we aimed to develop a pluralistic model of care to help improve patient access, consolidate and expedite care across all providers, and integrate treatment plans that work across the system. This is a rewarding new role for me since I have a strong interest and formal background in lean/operations engineering; a formalized process of examining [healthcare] systems from start to finish, defining workflows in detail and clearing barriers to improve efficiency and reduce waste.

What is a pluralistic model of care and why does it matter?
Patients have many choices in today's healthcare market in deciding who they see and where they go for their needs; these choices range from ED or urgent cares, private practice groups, or large healthcare networks. From an infrastructure standpoint, that really means the patient sees a multitude of different healthcare providers in different infrastructures of care, all utilizing a variety of payment models. At Henry Ford Health's main campus, care is streamlined under the umbrella of an academic employed physician model; however, our community-based satellite hospital campuses showcase both private practice (non-employed) physicians and staff working alongside other physicians in an employed position group.

This matters because employed and non-employed physician groups have different payment structures, different workflows, different clinics and different overheads with how we're running our operations- all with potentially different stakeholders and priorities. And, because patients seek care at multiple different places, we cannot operate in silos. Our goals, therefore, are to understand how to give patients the best care, while navigating these constraints. For example, if a patient sees a NP or ENT physician locally at a community Henry Ford hospital, can they receive all the care they need close to home? Or, if their issue is more complex and requires surgery, specialized equipment / testing, or subspeciality care, can we efficiently get them transferred within the system to the appropriate specialist/location, regardless of if the specialist is employed or non-employed?

On the back end, facilitating these pathways requires a keen examination of both patient and healthcare provider workflows, needs, resource allocations and constraints to best understand what is working, and more importantly- what is not. From there, we can understand how to best consolidate resources and come up with treatment care plans and models that work across the system in a quality oriented manner. These issues require transparency, trust and communication between all the different stakeholders involved to effectively come up with solutions that work well for under the system's infrastructure, but also support the financial model of the healthcare network as well.

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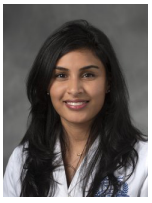
Short term goals

In the past year of working within this model we have made headway in not only establishing relationships with various stakeholders, but also identifying several places where our system is not as seamless as we would like it to be. One process improvement goal include systemwide improvements in consult and communication patterns amongst support staff and physicians by consolidating the variability in our current infrastructure that utilizes the electronic medical records orders, phone systems, and various HIPAA compliant messaging applications. This undertaking includes specific care pathways for urgent or time sensitive matters, including adjacent initiatives in determining how to efficiently transfer patients when they need higher levels of care from one facility to the other. For example, when a patient comes into the hospital and is determined to need an ENT consult, our new workflows help to quickly clarify which ENT group gets consulted (employed or non-employed), communicate the relevant and necessary information using the right technological platform, determine who sees them first (residents, nurse practitioner, or staff physician), and identify where we have the appropriate resources for best patient care.

Long terms goals

Although we are making excellent headway in our short-term goals, long term, we aim to continually improve our network for integrating ENT care at our satellite campuses to be an extension of our Main Campus care. If a patient is seen at one of the peripheral campuses, our goal is to keep most of their care locally whenever possible. If escalation of care, including subspecialty care, is needed, we aim to have "centers of excellence" at certain sites with dedicated resources, equipment, staffing and even research initiatives to help streamline care.

While there are many moving parts to this system, ultimately for the patient, this should be a seamless and efficient experience: the gold standard care for any Henry Ford patient.



Amrita Ray, D.O., MPH is a board certified, fellowship-trained otolaryngology - head and neck surgeon at Henry Ford Health with a specialization in rhinology and anterior skull base surgery.

Quick facts

Henry Ford Hospital has been recognized as a Best Hospital for 2024-25 in the Ear, Nose & Throat specialty by U.S. News & World Report, which features the top 50 of America's "Best Hospitals" in 15 specialties.

Henry Ford Otolaryngology

- Includes the Divisions of Audiology, Oral & Maxillofacial Surgery and a section of General Hospital Dentistry
- USNWR Top Hospital Ranking 3 years in a row (2017-2019)
- Otolaryngology services provided at 5 Henry Ford Health hospitals
- 8 outpatient clinics
- More than 3,500 surgeries annually
- More than 68,000 outpatient visits
- 26 otolaryngologists in the department
- 3 oral & maxillofacial surgeons with recruitment efforts for an additional 2 surgeons
- 2 general hospital dentists
- 23 audiologists, 4 audiology fellows
- 10 advanced practice providers
- 13 otolaryngology residents
- 1 head and neck cancer fellow
- More than $36M in patient revenue
- Department produced in 2023:
  peer reviewed publications = 57
  abstracts = 32
  oral/poster presentations = 25
- Approved OMFS residency program to begin AY 2024-2025

Head and Neck Cancer

- In top 10 percentile for time of initiation of postoperative radiation therapy for head and neck cancer patients < 6 weeks
- 900 surgeries
- Surgery services provided at all 5 Henry Ford Health hospitals
- More than 80 reconstructive cases annually
- 5,800 outpatient visits

Some Highlighted 2023 Manuscripts from our Team:

Tam S, Zatirka T, Neslund-Dudas C, Su WT, Cannella CE, **Grewal JS**, Mattour AH, Tang A, Movsas B, and **Chang SS.** Real time patient-reported outcome measures in patients with cancer: Early experience within an integrated health system. Cancer Med 2023; 12(7):8860-8870. PMID: 36670551. doi.org/10.1002/cam4.5635

Lyons AB, Ozog DM, Lim HW, Viola K, Tang A, and **Jones LR.** The Detroit Keloid Scale: A Validated Tool for Rating Keloids. Facial Plast Surg Aesthet Med 2023; 25(2):119-125. PMID: 35394356. doi.org/10.1089/fpsam.2021.0359

Eide JG, Mason W, Ray A, Carey J, Cook B, and **Craig JR.** Systematic review of errors on beta-2 transferrin gel electrophoresis testing of rhinorrhea and otorrhea. Int Forum Allergy Rhinol 2023. PMID: 37864574. doi.org/10.1002/alr.23293

Yaremchuk K. USPSTF Updates Recommendation for Obstructive Sleep Apnea Screening in Adults. JAMA Otolaryngol Head Neck Surg 2023; 149(1):5-6. PMID: 36378294. doi.org/10.1001/jamaoto.2022.3844

Donaldson LB, Deeb RH, Momin S, Eide JG, and Craig JR. Cadaveric and Computed Tomography Analysis of the Anterior Ethmoidal Artery Flap. Laryngoscope 2023; Epub ahead of print. PMID: 37950636

Williams AM, **Tam SH, and Adjei Boakye E.** Firearm Safety for Patients Diagnosed With Cancer-A Role in Suicide Prevention. JAMA Oncol 2023; 9(5):605-606. PMID: 36862388. doi.org/10.1001/jamaoncol.2022.7823
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Deeb R. Ethnically Sensitive Rhinoplasty. Facial Plast Surg 2023; 39(5):527-536. PMID: 37279876. doi.org/10.1055/a-2106-6677

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Chen AY, and Singer MC. Thyroid and Parathyroid Surgery: No Longer "Horrid Butchery". Otolaryngol Clin North Am 2023. PMID: 37640561. doi.org/10.1016/j.otc.2023.08.003

Howell RJ, Ekbom D, Kasperbauer J, Tabangin M, Altaye M, Wahab S, Belafsky P, Allen J, Amin M, Bayan S, Cervenka B, deSilva B, Dion G, Friedman A, Fritz M, Giliberto JP, Guardiani E, Harmon J, Khosla S, Kim B, Kuhn M, Kwak P, Ma Y, Madden L, Matrka L, **Mayerhoff R**, Piraka C, Rosen C, Wilson K, Wright C, Young V, Yuen S, and Postma G. Cricopharyngeus Muscle Dysfunction and Hypopharyngeal Diverticula (e.g., Zenker): A Multicenter Study. Laryngoscope 2023; 133(6):1349-1355. PMID: 36102298. doi.org/10.1002/lary.30387

Tam S, Neslund-Dudas C, Barrett AM, Barrow LCJ, Fridman I, Kinlaw AC, Puviindran P, Royce TJ, Smith AB, Stein JN, Wood WA, and Lafata JE. The Perceived Usability of Virtual Visits Among Black Adults' Receiving Oncology Care: A Qualitative Analysis. Oncologist 2023. PMID: 37756655. doi.org/10.1093/oncolo/oyad260

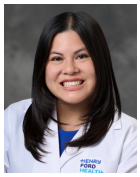
Adjei Boakye E, Nair M, Abouelella DK, Joseph CLM, Gerend MA, Subramaniam DS, and Osazuwa-Peters N. Trends in Reasons for Human Papillomavirus Vaccine Hesitancy: 2010-2020. Pediatrics 2023; 151(6). PMID: 37218460. doi.org/10.1542/peds.2022-060410

Choi E, **Leonard KW, Jassal JS,** Levin AM, Ramachandra V, and **Jones LR.** Artificial Intelligence in Facial Plastic Surgery: A Review of Current Applications, Future Applications, and Ethical Considerations. Facial Plast Surg 2023; 39(5):454-459. PMID: 37353051. doi.org/10.1055/s-0043-1770160

Henry Ford Health Otolaryngology Providers

To request a consult or referral to a Henry Ford Health physician, call (877) 434-7470 or refer a patient online.

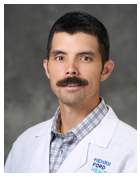
Comprehensive Otolaryngology



Linh Dang, M.D.

Alvin Ko, M.D.

Christie Morgan, M.D.

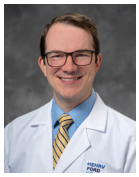


Tate Naylor, M.D.

Pavan Reddy, M.D.

Joshua Romero, M.D.

Ravi Shah, M.D.



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Endocrine Surgery

Michael Singer, M.D.
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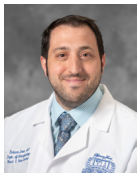

Robert Deeb, M.D.
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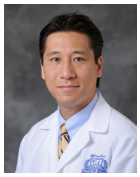
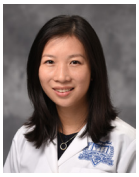
Lamont Jones, M.D.

Laura Garcia-Rodriguez, M.D.

Head and Neck Cancer Surgery



Steven Chang, M.D.
Department Chair



Samantha Tam, M.D.
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Vice-Chair

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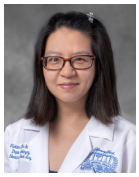

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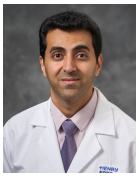
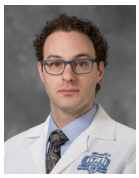
Syed Ali, M.D.



Rushil Dang, D.M.D., M.S.

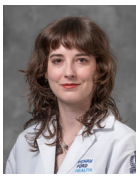
Suhael Momin, M.D.

Laryngology and Professional Voice



Ross Mayerhoff, M.D.
Division Head

Glendon Gardner, M.D.



Haley Sibley, M.D.

Oral and Maxillofacial Surgery

Jerrold Armstrong, D.D.S.
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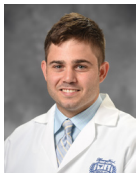
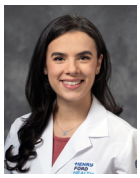


Benjamin Barbetta, D.M.D., M.D.

Jaroslaw Buda, C.N.P.

Hospital Dentistry



Angela Douglas, D.D.S.

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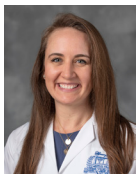
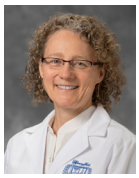
Otology and Neurotology



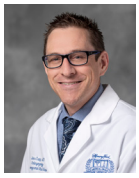
Kristen Angster, M.D.
Division Head
Vice-Chair



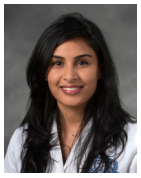
Laura Brainard, M.D.

Karen Enright, M.D., Ph.D.

Rhinology and Anterior Skull Base

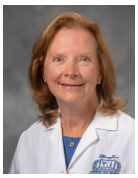


John Craig, M.D.
Division Head

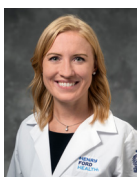


Amrita Ray, D.O.

Sleep Medicine



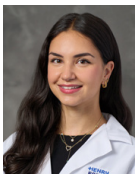
Kathleen Yaremchuk, M.D.
Chair Emeritus



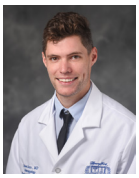
Andrea Plawecki, M.D.

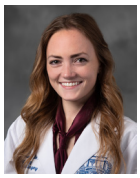
Otolaryngology Residents

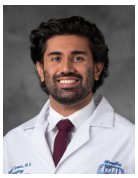

Abdurrahman Abdurrob, M.D.


Tala Al-Saghir, M.D.


Lane Donaldson, M.D.


Raven Dunn, M.D.


Madeline Goosmann, M.D


Jeewanjot Grewal, M.D.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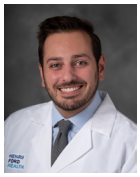
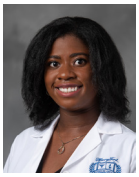
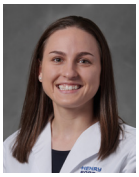
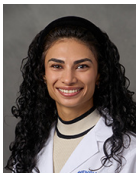
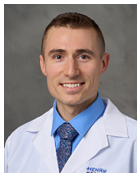
Kyle Leonard, M.D.


William Mason, M.D.

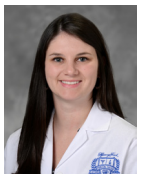

Oghenefejiro Okifo, M.D.


Kimberly Oslin, M.D.

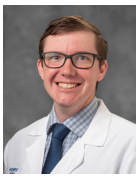

Zara Sragi, M.D.

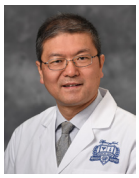

Benjamin Wils, M.D.

Advanced Practice Practitioners

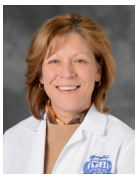

Rachel Bollman, M.S.P.A.S, P.A.-C.
Lead APP

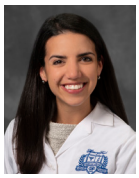

Kathleen Ackerman, P.A.-C.

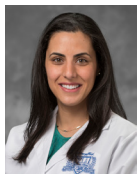

Scott Boyd, P.A.-C

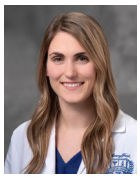

Wei Gao, M.S.M., P.A.-C.


Alexis Hernandez, P.A.-C


Michelle Mardegian, P.A.-C.


Loren Perlberg, A.G.A.C.N.P., BC


Reema Rahal. P.N.C., CNP, A.G.N.P.-C.


Riley Robinson, P.A.-C.

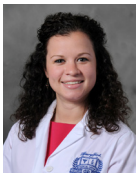

Elizabeth Steiner, P.A.-C.


Ghenoi Yasin, M.S.B.S., P.A.-C.

Audiologists

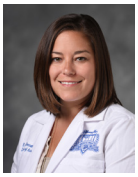
Brad Stach, Ph.D.
Division Head of Audiology

Patty Aldridge, AuD

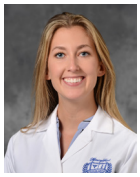


Erika Allan, AuD

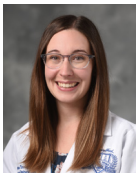
Taylor Arbogast, AuD



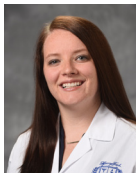
Erica Bennett, AuD, Ph.D.



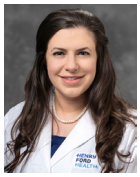
Ashley Bruce, AuD



Samantha Conn, AuD



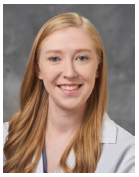
Chelsea Conrad, AuD



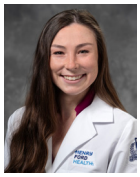
Lauren G Dadisho, AuD

Ashley Deeb, AuD

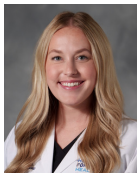
Garrett Findlater, AuD



Kassandra Fitzgerald, AuD

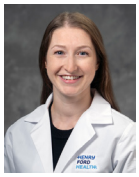


Emma I Garber, AuD

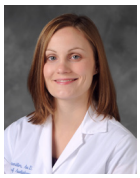


Haley Garr, AuD

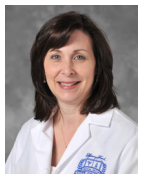
Mary J Kassa, AuD



Rachel Kirby, AuD

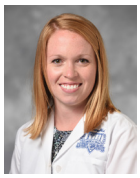


Kellie Kornmiller, AuD

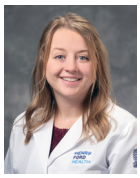


Jeanne Livernois, AuD

Brian C Lloyd, AuD

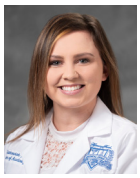


Katie Makowiec, AuD

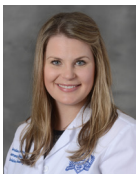


Ashley M Pudelek, AuD

Wendy Rizzo, AuD



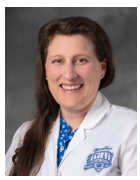
Nicole Satkowiak, AuD



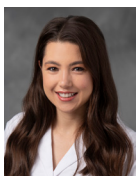
Jordan Simmons, AuD

Karrie Slominski, AuD

Kaylee Smith, AuD



Jessica Strabbing, AuD



Nicole Velander, AuD