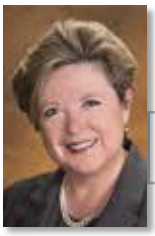
THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | DECEMBER 2019



Gratitude: Looking Back and Ahead

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

My first message as Chief of Staff is to express decades of gratitude for your guidance in helping me serve my patients. When I was hired nearly 25 years ago by Dr. Spadafore (medical director of the former St. Luke's Emergency Department) and Dr. Wolford (founding program director for the Emergency Medicine Residency program), it was to help start the residency program by serving as a core faculty member. Back then, I could not have imagined the amazing experiences I have subsequently had at Covenant HealthCare.

Amazing Staff

In emergency medicine, we are expected to know a little about everything, but most importantly to know when the patients need more help than what we can provide. It is this truth that I want to make certain you are aware of, because your answers to our pleas for help have been greatly appreciated.

In fact, because of the amazing medical staff at Covenant, we've been able to grow the annual census from less than 30,000 to more than 94,000 over the past two and a half decades. Having your collective support truly makes the whole system successful. The patients benefit, the community benefits and yes, we as healthcare providers also benefit.

Incredible Learning

Now, with the alignment between Covenant and the CMU College of Medicine, we are securing success for the next generations too. Together, we are guiding the future as we support an incredible learning environment and teach medical students and residents what each of us know. Future surgeons, cardiologists, oncologists and others must continue to have the opportunity to take from us the best of what we can teach to them. After all, they will be caring for tomorrow's patients, including our loved ones and ourselves.

The age of information technology is certainly giving younger physicians a host of exciting learning tools that we older physicians never had, including today's online encyclopedia of medical knowledge.

Back in the day, I longed for a resource that could rapidly show me what a particular rash looked like or how to perform a procedure I had never done. Now, our interns can access amazing introductory procedural boot camps that help them master their skills faster while staying focused on patient safety and extraordinary care. They can look up a problem instantly on their smart device, research what "Up to Date" says, or see what is available by FOAM (Free Open Access Meducation).

Extraordinary Experience

The resources available through information technology are incredible, but they will never replace YOUR extraordinary experience, interaction and personal guidance. Our interns still need **YOU** at their side to round out their skills with the valuable knowledge and insights you simply can't get in books or online.

On behalf of everyone in emergency medicine, thank you again for taking our calls and answering our requests for help. Optimizing results requires contributions and teamwork across the entire healthcare system, including collaboration with emergency medicine. I, for one, am forever grateful for your help.

Sincerely,

K Cowling

Kathleen Cowling

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Rethinking Weight Loss

Dr. Dafina Allen, Family Medicine and Obesity Medicine, Covenant Medical Group

Patients with obesity run the risk for a plethora of comorbid conditions and diseases. There are many factors behind weight gain, from menopause, stress and anxiety to obstructive sleep apnea, inactivity, medications, genetics and hormones. Some weight fluctuation is normal but when weight keeps going up, healthcare providers should intervene right away to prevent further problems.

Using the Five A's

Fighting the obesity epidemic requires a new way of thinking about weight loss. Instead of telling patients to "eat less and move more," better results can be achieved using a proactive approach centered on the five A's of "ask, assess, advise, assist and arrange."

- **Ask:** For patients with BMIs under 30 but steadily gaining weight, discuss your concerns at an appointment and without judgment. For patients with a BMI of 30 or more, or a BMI of 27 or more with a medical condition, ask if they are interested in a weight loss plan.
- **Assess:** Resist the stereotype that obesity is due to laziness or caloric intake. Review all factors related to the patient's weight gain, including medications, medical conditions and eating habits. If the patient is stress-eating or too tired to exercise, there may be an underlying condition such as chronic fatigue syndrome, anxiety or sleep apnea. Unexplained weight gain can also be due to medications, depression and hypothyroidism.
- **Advise:** Have a compassionate yet informative conversation with the patient to help them understand the consequences of obesity (e.g., increased risk of CAD, hypertension, hyperlipidemia, diabetes and sleep apnea). If you don't bring it up, the patient might assume it is not an issue.
- **Assist:** Give your patient tools that empower them to change how they eat. This should include an action plan with diet, nutrition and exercise goals. It may also include changes to medications that do not cause weight gain. Monitor their progress and course-correct as necessary.
- **Arrange:** If no headway is made in patients with obesity in three to six months, anti-obesity medications may be an option. You can also refer more complex cases to weight loss experts.

Charting a Course of Action

Below are additional tips for charting a personalized course of action:

- Start the patient with a realistic short-term goal of losing 5-10% of their current weight, and a long-term goal as well. Even a 5% loss can significantly decrease risk factors.
- Diet should be the primary focus for weight loss. Emphasize that diet plays a larger role than exercise, although exercise is important for weight management and cardiovascular health.
- A weight loss diet should consist of whole, unprocessed foods that are low in simple carbohydrates (white flour and sugar) and high in healthy fats, vegetables and protein.
- Patients can start with exercise at least three days a week for 15-20 minutes per session (walking is a great start). This can be increased gradually, with a goal of moderate cardio activity for one hour at least five days per week, with two weight-bearing exercises as well. Remind struggling patients that some exercise is better than nothing.
- Once the patient is close to their long-term weight loss goal, discuss a maintenance plan to keep it off.
- Refer morbidly obese patients for bariatric surgery if they have a BMI of 40 or more, or a BMI of 35 or more with a comorbidity. Most bariatric centers have experts to manage weight loss requirements.
- Tap into the American Heart Association (search "Life's Simple 7"), Academy of Nutrition and Dietetics, Obesity Medicine Association and The Obesity Society for guidance.

Weight loss conversations are never easy to have, but they are better than seeing patients suffer the consequences. By treating obesity as a major disease versus a stigma, and by taking a proactive stance, we can improve the health of our patients, communities and nation.

For more information, contact Dr. Allen at 989.583.5300 or dafina.allen@chs-mi.com.

The Importance of Patient Safety Indicators

Dr. Glen Cipullo, Medical Director of Clinical Utilization, Covenant HealthCare

The top priority for Covenant HealthCare physicians is providing safe, quality care for their patients. This requires accurate documentation which in turn ensures accurate coding and billing. It also enables various agencies to collect profile data and publish results on websites that are free to the public. Healthgrades, for example, states that it makes "information on physicians and hospitals more accessible and transparent … to give people the confidence to make the right healthcare decisions."

One way data is reported is through Patient Safety Indicators (PSIs), a set of measures that screens for adverse events experienced by patients exposed to the healthcare system. Being aware of these measures can help identify areas of improvement at both the hospital and provider level.

PSIs Defined

PSIs are a set of 26 indicators, including 18 at the provider level, developed by the Agency for Healthcare Research and Quality (AHRQ) to provide information about safety-related adverse events in hospitals following operations, procedures and childbirth. PSIs use data in the discharge records to identify possible in-hospital complications and potentially avoidable safety events.

PSIs have roots in the Institute of Medicine's definition of patient safety: "Freedom from accidental injury caused by medical care." This has been updated to include: "The failure of planned action to be completed as intended or the use of a wrong plan to achieve an aim."

Key Benefits

PSIs represent a significant advance in methodology for capturing information that helps improve the quality and safety of patient care. PSI reporting:

- Identifies issues that can potentially compromise patient safety and warrant further study.
- Drives both prevention and improvement opportunities based on accurate data.
- Helps hospitals and providers assess, monitor and track inpatient care for safety concerns.
- Enables comparative public reporting and trending data.
- Offers data that can be used in pay-for-performance initiatives.
- Uses area-level indicators to help assess total incidences at a regional level (measured as rates based on outcomes of interest / population at risk).

Case In Point

In 2018, Covenant HealthCare held a rapid improvement event (RIE) related to PSI #11 – "Post-Op Respiratory Failure." One focus of the RIE identified the opportunity for physicians to correctly document patient cases in which a patient remains intubated post-operatively and does not meet criteria for acute post-operative respiratory failure.

In these cases, the primary reason the patient remains intubated from surgery with ventilator support is related to non-pulmonary insufficiency. This diagnosis validates the use of ventilator support for patients not truly intubated for the condition of acute respiratory failure.

A tool was developed to assist in determining the correct diagnosis, and to distinguish the difference between acute post-op pulmonary insufficiency and acute respiratory failure (please see table below).

Such tools are only possible through accurate documentation from all healthcare providers, including physicians. As mentioned, this drives accurate coding, billing and data retrieval for the purpose of improving the quality and safety of the patients in our care.

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

Documentation for Post-Op Patients Who Remain Intubated

Acute Post-Op Pulmonary Insufficiency ***NON*-Pulmonary Pathology**	**Acute Post-Op Respiratory Failure** ***ACUTE* Pulmonary Pathology**
• Acute delirium • Chronic pulmonary pathology* • Chronic heart failure • Encephalopathy • Hemodynamic instability • Intoxication • Known difficult airway • Pre-existing dementia • Planned return to OR • Sedation • Traumatic brain injury/acute neurotrauma	• Acute pulmonary edema – non-cardiac • Acute respiratory distress syndrome • PF ratio: <300 • Pneumonia / aspiration pneumonia / pneumonitis • Pulmonary trauma • O2 requirement of 40% or more (>4 hours)** • >48-hour ventilator support • Arterial blood gas / ABGs (1 or more)** – pO2 <60 – pCO2 >50 and pH <7.35 (>4 hours) – pO2 decrease or pcO2 increase by 10 mmHg from baseline if known

**Exception for non-pulmonary pathology*

***Source: ACP Hospitalist, Oct/Nov. 2013*

Treating Depression and Preventing Suicide Among Youth and Young Adults

Dr. Christa Persyn, Emergency Medicine, Covenant Medical Group

Suicide is the second leading cause of death for youth and young adults aged 10-24 years in Michigan, with most deaths occurring among males between ages 20-24. Healthcare providers are in a unique position to help turn the tide by recognizing the signs of depression and providing timely treatment.

This Time of Year Is Especially Important

By now, most of our youth have returned to school or college, which presents new stressors that can lead to depression. Variations in routine, academic pressures, relationships, bullying and an ever-growing social media circle are just a few major issues that young people face, not to mention coping with the holidays and controversial world events.

Youth might not want to talk about their depression and suicidal thoughts, or get help, due to the stigma and embarrassment associated with it. Too often, the media reinforces that stigma. It is critical that providers counterbalance that perception with positive actions, education, solutions and resources for these patients – and an open line of communication.

Looking for Subtle Signs Can Reveal a Deeper Problem

Providers face tight time constraints with every visit. It's easy to focus on a chief complaint and miss subtle clues that indicate depression. Many screening tools for depression can be integrated into the EMR and completed by the patient while waiting. Regardless, providers should also be diligent about asking the patient questions about home, work and school. This might be just the opening the patient is looking for.

See the sidebar for subtle signs of depression and key suicide risk factors. If the patient shows any of the signs, a more detailed discussion should occur and/or the provider should make an immediate referral to a mental health expert.

Reinforce That Help Is Here

Patients who indicate suicidal thoughts need to understand that it is not a common or acceptable response to stressful situations, and that there are better solutions. Positive messages to share include:

- You can take action to prevent depression and suicide.
- You have people who care and want to help.
- Prevention and treatment work.
- Resilience and recovery are possible.
- Effective programs and services exist.

Depression responds best to a multimodal treatment combining patient and family education, cognitive behavioral therapy and antidepressant medications. Even a basic plan inspires hope and confidence.

Let's Destigmatize Depression

Everyone knows someone who suffers from depression, or has attempted or committed suicide. The stigma attached to it, in addition to financial barriers and a storage of mental health professionals, prevents many people from getting the treatment they need.

As healthcare providers, we have the power to foster a culture of awareness, understanding and education that destigmatizes depression and prevents suicides. We can also continue to advocate for better insurance coverage and greater access to mental health services for everyone, including those who live in underserved areas. In this way, we can make sure that our youth and young adults get the treatment they need, when they need it most.

For more information, contact Dr. Persyn at cpersyn@chs-mi.com or 989.798.4700.

Subtle Signs of Depression

- Withdrawal from activities
- Trouble sleeping
- Difficulty concentrating
- Changes in appetite or weight
- Lack of energy
- Feeling hopeless or worthless
- Self-destructive behavior
- Physical symptoms that do not respond to treatment
- Drug and alcohol abuse
- Interest in weapons

Risk Factors* for Suicide

- Youth who were bullied online were four times more likely to consider suicide.
- LGBTQ youth were four times more likely to consider suicide than heterosexual youth.
- Youth that experienced physical or sexual dating violence were five times more likely to attempt suicide.
- Youth that were injured in a physical fight and had to be treated by a doctor or nurse were five times more likely to attempt suicide.

Useful Resources

- Michigan Department of Health & Human Services MDHHS website
- Saginaw County Community Mental Health Authority 24-Hour Crisis Hotline: 989.792.9732 or 1.800.233.0022

**Source: MDHSS Fact Sheet*

Neurostimulation for Complex Pain: The Dorsal Root Ganglion

Dr. Erich Richter, Neurosurgeon, Covenant Medical Group

With the opioid epidemic still raging, non-opioid strategies for treatment of chronic pain are increasingly important. Neuromodulatory techniques, such as spinal cord stimulation (SCS) and intrathecal drug delivery have been used for decades, but newer forms of neural stimulation are proving effective for disorders that were previously refractory.

One exciting advance is dorsal root ganglion (DRG) stimulation. It is FDA-approved for patients diagnosed with chronic, intractable pain in the lower limbs who do not respond to physical therapy, behavioral management, nerve blocks and other traditional treatments. This option can help a patient avoid a larger surgery, manage the pain after a surgery when the underlying structural cause has been adequately addressed (neuropathic post-operative pain), avoid the need for chronic narcotics and increase function.

The Evolution

Traditional SCS aims to create a paresthesia over the painful area, and if mapped adequately can provide substantial pain relief for more than half of patients. However, many patients remain who don't get substantial relief. In addition, certain pain distributions such as the groin, knee or bottom of the foot have proven difficult to map paresthesia with traditional SCS, lowering success rates in these patients.

SCS breakthroughs over the past 10 years include paresthesia-free stimulation patterns that produce higher pain relief results, and DRG stimulation technology which targets painful areas that traditional SCS finds difficult to cover – opening the therapy door to many patients who were previously untreatable.

The DRG holds the sensory nerve cell bodies for each peripheral nerve root as it enters the spinal cord. It is accessible from the epidural area of the spinal canal. Each ganglion acts as a "sensory gate," modulating sensory messages as they travel to the spinal cord. By stimulating the proper ganglion, specific painful areas can be targeted and modulated.

While this is true at any spinal level, the clinical importance is most noteworthy in those areas that previous technologies were ineffective at treating, such as persistent neuropathic pain in the groin or knee after successful repair of a hernia or knee, or the bottom of the foot in painful neuropathies.

The Procedure

The DRG device features up to four electrical leads and an implantable pulse generator placed under the skin in the buttocks or abdomen. Candidates are evaluated with an MRI to ensure there is adequate room in the spinal canal for the electrodes, which are about a millimeter in diameter. Temporary electrodes are implanted as a percutaneous outpatient surgical procedure much like an injection, allowing the patient to trial stimulation for about a week to determine effect.

Most patients find the pain relief dramatic, and are able to avoid narcotic medications and increase activities. These patients return for a second outpatient procedure for a permanent, fully implanted device. In clinic, the leads are programmed to the pain pattern, often requiring two visits for full optimization. Patients can control the therapy in real time with a hand-held device.

Encouraging Results

Studies show DRG stimulation has superior one-year outcomes over traditional SCS treatments. According to a 2017 *Pain* study, compared with traditional SCS:

- DRG stimulation has a higher rate of treatment success (81.2% versus 56.7%).
- Pain relief persisted through 12 months of follow-up and remained significantly lower for DRG subjects.
- DRG subjects reported much higher quality of life, functional status and psychological disposition.

Various other studies reinforce these findings. The ACCURATE study, for example, reports that 94.5% of patients received targeted stimulation without paresthesia compared to 61.2% receiving traditional SCS. A separate study of patients after knee surgery showed that opioid usage was reduced by about 87% after six months.

Recommendations

For patients experiencing chronic pain due to injury or surgery that does not respond to medical or physical therapies, DRG stimulation is proving to greatly improve pain control and quality of life. If you have a patient with unrelenting nerve pain, consider this as a serious option.

For more information, contact Dr. Richter at 989.598.6562 or erich.richter@chs-mi.com.

Advanced Technologies for Diabetic Patients

Dr. Amer Issa, Endocrinology, Covenant Medical Group

Around nine percent of the United States population has diabetes, or 30 million people. Another 84 million have pre-diabetes. Most of these patients, especially those with type 2 diabetes, are managed by primary care physicians.

Technical advancements have allowed for revolutionary technologies to play an important role in diabetes management. Benefits include easier tracking of carbohydrate intake, more meaningful monitoring of blood glucose values, more convenient ways to deliver insulin, improved compliance with treatment plans and better glycemic control.

Today's tools for diabetics are painless, convenient and real timesavers. Your familiarity with them will help you keep patients informed and confident, spot trends and recommend opportunities for improvement. A few examples are described below.

Advances at a Glance

- **Monitoring Apps.** About 50 thousand applications (apps) have been designed for diabetics. These apps can help record blood glucose readings, food, medications and activity – making it easier to track trends and issues. Some apps also link patients to online support communities and registered dietitians.
- **Connected self-monitoring blood glucose (SMBG) meters.** Whether as Bluetooth-enabled meters that pair with the above-mentioned apps or connect to the cloud, these meters automatically send blood glucose readings to the user.
- **Continuous glucose monitoring (CGM).** Our understanding that the "optimal glycemic control" is simply achieving a target hemoglobin A1c (HbA1C) level has recently changed. A given A1c can be associated with a wide range of mean glucose concentration between individuals. Furthermore, multiple factors can affect the accuracy of A1c measurement. Therefore, using HbA1C alone can be misleading. Correcting glycemic variability and optimizing "time in range" are emerging targets. CGM provides data that can be helpful in achieving these goals.

  The CGM tool uses a sensor to measure blood glucose levels at regular intervals. The data can be transmitted to a cloud or smartphone, allowing users to view it in real time and act quickly to avoid dangerous events. The data can also be shared with physicians and family.

  The new CGMs are smaller, more accurate and calibration-free, eliminating frequent finger-pricking. Studies show they can reduce A1c by 0.5% and reduce the frequency of hypoglycemia and severe hypoglycemic episodes. It is particularly beneficial for type 1 diabetics, and for type 2 diabetics treated with multiple daily injections of insulin.

APPROXIMATELY 30 MILLION PEOPLE IN THE UNITED STATES HAVE DIABETES

- **Smart insulin pens.** This Bluetooth-enabled, reusable pen injector brings user-friendly bolus calculating and data tracking to diabetics. Every time the patient delivers an insulin bolus, the pen transmits data to a secure app on their smartphone. App features include insulin on-board tracking, dose history data, a bolus calculator, dose reminders and an insulin temperature monitor. The app also receives CGM data and generates a shareable report with the time and dose of the bolus insulin.
- **Hybrid closed-loop system insulin pump.** The pump automatically adjusts basal insulin every five minutes based on the CGM reading, helping to keep the sugar level in the target range for fewer hyperglycemia and hypoglycemia events. A "suspend before low" feature allows the basal insulin infusion to be suspended for up to 30 minutes before reaching the preset low limits. It then automatically restarts insulin when the glucose level recovers, which helps avoid lows and rebound highs. A personalized closed-loop system with automatic bolusing is currently being developed.

Key Take-Aways

Recent technology advances have significantly improved the quality of life for diabetic patients everywhere, saving time, frustration and lives. It's important for providers to be familiar with these advances and the benefits they bring to patients. Despite those benefits, though, the patient's access can be restricted due to limited insurance coverage and/or high costs.

If you have questions or want additional insights, remember to consult with an endocrinologist, including those at Covenant HealthCare. They can provide updates on new tools and treatments for your diabetic patients.

For more information, contact Dr. Issa at 989.583.5308 or amer.issa@chs-mi.com.

Medication-Induced Depression?

Paul Thill, PharmD, Ferris State University and Joshua Nelson, PharmD Candidate, Ferris State University

According to the National Institute of Mental Health, in 2017 an estimated 17.3 million adults in the United States experienced at least one major depressive episode as defined by DSM-5* criteria. This equates to roughly 7.1% of all adults ages 18 and older.

While these numbers are staggering, they are not surprising due to the aging U.S. population, an increase in chronic disease and a resultant increase in polypharmacy prescribing. The latter raises concerns since depression and suicidal ideation are potential side effects of many medications. This is an issue that healthcare providers should consider in their patient discussions and treatment plans.

Certain Drugs Linked to Depression

In June 2018, National Public Radio (NPR) released an article linking many common drugs and drug classes to depression. The list includes proton pump inhibitors, beta blockers, anti-anxiety medications, pain killers and anticonvulsants.

Mark Olfson, a researcher and professor of psychiatry at Columbia University, said in an NPR interview, "If you take the time to actually go through the fine print and read the insert, you will find that each of these medications lists depression as an adverse effect." His statement is the result of a cross-sectional survey study published in the Journal of the American Medical Association (JAMA), which reports that in individuals using three or more medications with depression as a known side effect, 15% have been clinically diagnosed with the condition.

Education versus Misinformation

With today's internet accessibility and social media usage, healthcare providers are dealing with an increasingly educated patient population. While this supports patient-driven care, misinformation or hype can prevent optimal treatment.

For example, providers could hesitate to prescribe the drug of choice. However, they should know that while the aforementioned study draws a link between depression and some medications, it does not establish causality. Furthermore, many medications listed as "common offenders" in the NPR news story are used to treat chronic conditions such as pain and cardiovascular disease, which alone can exacerbate depression. The depression could be caused by the condition, not the medication.

Therefore, providers are strongly encouraged to use good clinical judgement when choosing the best therapy for patients.

Tips for Prescribing Meds

Consider the following tips when prescribing medications linked to depression:

- **Offer Non-Pharmacological Treatment First.** Before prescribing medications, non-pharmacological therapy should always be a first choice when possible. Not only does this help reduce polypharmacy, potential drug interactions and side effects, it also often treats the patient's problem at its core. While alternative therapy and lifestyle management alone may not be an option, they both can promote synergy with drug therapy and help the patient feel more in control of their health – and thus less anxious.
- **Listen Carefully.** Most patients who take multiple medications do not have a choice. This can cause depressive thoughts, as can treatment costs, improper dosing and medication side effects. Therefore, it is important to listen to patients, identify the root cause of depressive feelings, and determine if it is psychological, economical, pharmacological or physiological in nature. This could avoid antidepressants or psychotherapy.
- **Remember, Pharmacists Are Great Resources.** It can be difficult to manage patients with extensive medication lists. Pharmacists can help provide insight on adverse effects, interactions and initiation for all medications. This can help reduce polypharmacy and optimize treatment regimens.

It is natural for healthcare providers to clinically interpret patient health data, connect the dots and draw conclusions. It is equally important to look at the human side, as well, such as the impact of medicines and psychological, economical and social stressors on patient behaviors. Taking this deeper view can help all of us better manage the patient's overall health and well-being.

For more information, contact Paul Thill at 989.583.6512 or thillp@ferris.edu.

COVENANT HealthCare

Extraordinary care for every generation.

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THE CHART SPOTLIGHTS

CONGRATULATIONS PHYSICIANS OF THE MONTH!

Your patients and colleagues are saying extraordinary things…

OCTOBER

Dr. Sussan Bays | BREAST SURGERY

"Dr Bays is great; I feel very comfortable with her and her staff. It is the second visit for me and I feel very confident under her care!"

"I felt very comfortable talking with Dr. Bays. She is very easy to converse with and seems to really listen and care."

"I feel as if Dr. Bays is an excellent doctor. I thank God for being referred to her."

NOVEMBER **Dr. Kurt Menapace | ORTHOPAEDIC SURGERY**

"Dr. Menapace and his PA, Luke, make an excellent team. I felt their concern for me was sincere plus their knowledge and experience helped in my healing process."

"Dr. Menapace is very attentive to his patients. He listens well, gives clear information and instructions, and is very polite!"

"Dr Menapace is wonderful, very kind, thorough and patient; an excellent bedside manner."

DECEMBER

Dr. Tracy McComb | INTERNAL MEDICINE/PEDIATRIC MEDICINE

"Dr. Tracy McComb was fantastic. She listened, explained everything and really has a calming nature. I couldn't have been more pleased."

"Dr. McComb was wonderful. She sat down and listened to me to get my history. I really felt like she cared, even though she has never seen me before. I really appreciated that and I highly recommend her to everyone."

"I really liked Dr. McComb's attitude and sense of humor. She took the time to explain everything."