THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | September 2016

Is "Bob" Back Again?

Dr. James Hines
Covenant HealthCare Chief of Staff

While I was a student at Indiana University School of Medicine in 1977, one of my friends – let's call him "Bob" – would always dwell on an illness after seeing it in a patient or studying some exotic disease. One week he would have a brain tumor, then it would be Crohn's disease, then kidney disease or heart failure, or pancreatic cancer. This hypochondriac behavior continued until years later when he died of a melanoma and said, "I just knew I had something serious."

Most of us have had a "Bob" in our office, but hypochondria is a tough condition to diagnose and treat. The American Psychiatric Association's list of symptoms is shown in the sidebar to the right.

In 2013, the diagnosis of hypochondriasis was eliminated from the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.). It is now categorized as ***somatic symptom disorder*** (if the physical complaints are prominent) or ***illness anxiety disorder*** (if physical complaints are absent or minimal).

Of all patients suffering with this condition, about 75% have somatic symptom disorder and 25% have illness anxiety disorder.

Treating "Bob"

Physicians who have treated a "Bob" know that it can be extremely challenging. We confirm, encourage, double-check and reassure. It often requires a lot of testing and follow-ups, all in the effort to "prove" to the patient (and ourselves) that they are not dying.

It is not only frustrating for us, but also for the patient, because they truly feel the symptoms! Through it all, I urge you to exercise patience and to remember the following:

1. Don't assume one of the disorders listed above and discount the complaint, because it could be legitimate. The patient's symptoms can actually be pointing to a real illness that is difficult to diagnose.
2. Different health complaints over a short period of time, such as painful IBS one visit, concern over a tick bite another time or strange moles on yet another visit, could actually be a coincidence of actual ailments converging at once.
3. If repeated testing of numerous ailments over time reveals no medical cause, perhaps the patient DOES have one of the two disorders listed above. If so, you need to ask what is triggering the disorder and how you, their physician, can help turn things around.

Continued on page 12

Symptoms of Hypochondria

1. Preoccupation with or fear of having a serious illness based on a misinterpretation of physical symptoms.
2. Continuing preoccupation despite being medically evaluated and reassured by a physician that you are not sick.
3. Your preoccupation causes you significant distress and prevents you from functioning normally at home and at work.
4. The preoccupation continues for at least six months and can't be explained by any other type of mental illness.

**American Psychiatric Association*

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Joint Replacement Coverage Update

GUEST AUTHORS
Dr. Anthony de Bari, Orthopaedic Surgeon
Kyle McDaniel, MSN, RN and Manager of Clinical Resource Management

As of April 1, 2016, joint replacement coverage under Medicare has officially changed. The Centers for Medicare & Medicaid Services (CMS) launched a mandatory Comprehensive Care for Joint Replacement (CJR) model that is focused on driving efficiency and quality for beneficiaries of hip and knee replacements. It is part of an effort by CMS to move from fee-for-service models for their Medicare Part A and B beneficiaries to alternative payment models, such as bundled payments like CJR.

Under this new model, hospitals hold the risk related to these procedures. They could receive additional payments from Medicare at the end of each year, or may potentially need to repay Medicare for a portion of the spending.

What Triggered the CJR Model

The CJR model – the first of its kind for orthopaedics – was triggered by concerns over the growing volume and cost of total knee and hip replacements in the United States. These procedures continue to be the most common inpatient surgery and require intensive recovery and rehabilitation.

Equally concerning was the disparity of costs and quality among hospitals. CMS identified approximately 800 hospitals in 67 geographic areas that perform these procedures and found that the average spend across the continuum of care ranges from $16,500 to $33,000. This wide gap clearly demonstrates room for improvement in all phases of care.

How Reimbursement Works

For each of the next five years of the CJR model, CMS will designate target-spend totals for knee and hip replacements for all hospitals in this program. These target prices reflect the cost per beneficiary from inpatient admission through the 90-day episode of post-acute care following surgery.

All providers and suppliers will continue to be paid under the current rules and procedures throughout the year. However, hospitals will be held financially accountable for meeting spend targets. CMS will track the episodic spend quarterly and then reconcile the spend at year end to determine the average cost for these procedures. If the hospital's average spending is above the set target price, it may be required to pay a penalty. If below, it may get rewarded with an additional payment. These risks and rewards change throughout the five-year pilot program, increasing risk on the hospital each year.

Beneficiaries are still free to choose services and providers, and all other safeguards and standards required by Medicare remain in place. The hospital, however, does not have the ability to opt out of this program.

CMS identified approximately 800 hospitals in 67 geographic areas that perform these procedures and found that the *average spend* across the continuum of care ranges from $16,500 to $33,000.

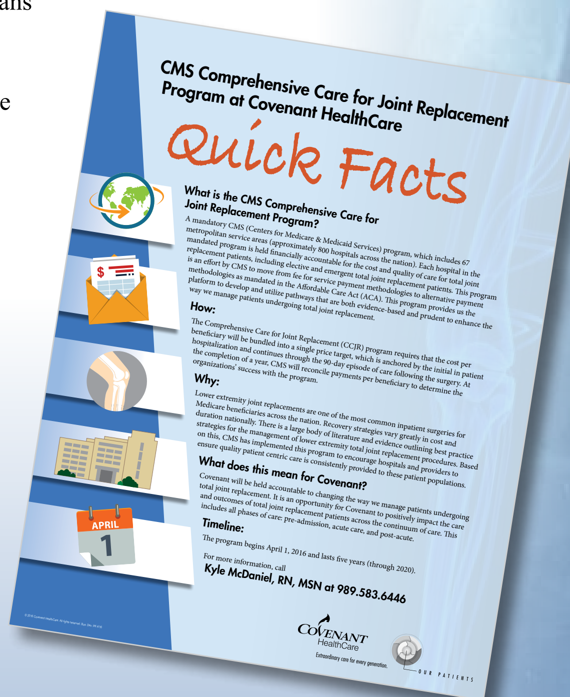
Driving Change

To avoid getting penalized, a strategy to control and reduce spend throughout the continuum of care is essential. Success will require increased coordination of care between everyone involved – hospitals, physicians and post-acute care providers. Covenant HealthCare, for example, is already taking several steps to effect change, including:

- Identifying and implementing process changes recommended by a special multidisciplinary team representing the continuum of care.
- The development of Care Pathways to facilitate safe, effective and more efficient delivery of care for patients receiving total hip and knee replacements.
- Ensuring these enhancements attest to the tenets of "Our Covenant" to ensure a collaborative effort to positively impact patient care and outcomes while reducing costs.
- A "Quick Facts" sheet is being distributed to physicians to reinforce awareness and support.
- Monthly updates to orthopaedic surgeons and staff about the CJR model is also underway to keep people informed and to obtain feedback.

The CMS implementation timeline for the CJR model is April 1, 2016, through 2020, providing enough time for hospitals to change the way they manage patients and spending.

For more information, including a "Quick Facts" sheet, contact Kyle McDaniel at 989.583.6446 or kmcdaniel@chs-mi.com.



CMS Comprehensive Care for Joint Replacement Program at Covenant HealthCare

Quick Facts

What is the CMS Comprehensive Care for Joint Replacement Program?

A mandatory CMS (Centers for Medicare & Medicaid Services) program, which includes 67 metropolitan service areas (approximately 800 hospitals across the nation). Each hospital in the mandated program is held financially accountable for the cost and quality of care for total joint replacement patients, including elective and emergent total joint replacement patients. This program is an effort by CMS to move from fee for service payment methodologies to alternative payment methodologies as mandated in the Affordable Care Act (ACA). This program provides us the platform to develop and utilize pathways that are both evidence-based and prudent to enhance the way we manage patients undergoing total joint replacement.

How:

The Comprehensive Care for Joint Replacement (CCJR) program requires that the cost per beneficiary will be bundled into a single price target, which is anchored by the initial in patient hospitalization and continues through the 90-day episode of care following the surgery. At the completion of a year, CMS will reconcile payments per beneficiary to determine the organizations' success with the program.

Why:

Lower extremity joint replacements are one of the most common inpatient surgeries for Medicare beneficiaries across the nation. Recovery strategies vary greatly in cost and duration nationally. There is a large body of literature and evidence outlining best practice strategies for the management of lower extremity total joint replacement procedures. Based on this, CMS has implemented this program to encourage hospitals and providers to ensure quality patient centric care is consistently provided to these patient populations.

What does this mean for Covenant?

Covenant will be held accountable to changing the way we manage patients undergoing total joint replacement. It is an opportunity for Covenant to positively impact the care and outcomes of total joint replacement patients across the continuum of care. This includes all phases of care: pre-admission, acute care, and post-acute.

Timeline:

The program begins April 1, 2016 and lasts five years (through 2020).

For more information, call
Kyle McDaniel, RN, MSN at 989.583.6446

CMS will designate target-spend totals for knee and hip replacements for all hospitals in this program. If the *hospital's average spending is above the set target price,* it may be required to pay a penalty. If below, it may get rewarded with an additional payment.

The Covenant HealthCare Cancer Concordance Study: One Year Later

INTERVIEW WITH

Dr. Peter Dempsey, Medical Director, The University of Texas MD Anderson Cancer Center

Recently, the following interview was conducted with Dr. Peter Dempsey about Covenant HealthCare and its recently completed Concordance and Quality Indicators Assessment Study.

Q. What is a Concordance study?

A. In June 2015, Covenant HealthCare became an official, certified member of the University of Texas MD Anderson Cancer Center. During the first year for any new member, we perform an extensive Concordance and Quality Indicators Assessment Study on what we call the Big Four cancers: breast, lung, prostate and colorectal. The goal is to benchmark how well the member hospital and clinics meet oncology guidelines, quality indicators and best practice benchmarks used at MD Anderson Cancer Center.

I am happy to say that Covenant passed the Concordance study with flying colors and is considered to be among the best of certified members.

Q. How is the Concordance study performed?

A. The MD Anderson Cancer Center assigns a member of its Physician's Network – in this case, me – to work as a medical director advocate with the Certified Member's Cancer Committee – in this case, Covenant HealthCare. As part of our process, interested oncology physicians at Covenant HealthCare were asked to voluntarily supply their charts to our team over a period of one year – which added up to between 10 to 25 charts each. These charts, sorted by cancer type, were then carefully reviewed in great detail by active clinical faculty at MD Anderson. The reviews conducted by active clinical faculty at MD Anderson are quite intense, covering everything from when the patient presents, to achieving a diagnosis, the testing methods and sequence used, treatment planning, and so on – even noting if the pretreatment diagnosis matched the final diagnosis and clinical staging. When you deal with entities such as radiation (in both workup imaging and treatment), chemotherapy, etc., the first priority is always patient safety. The other priority, of course, is achieving the correct diagnosis and choosing the appropriate treatment.

After the study was complete – and all four major cancer sites were carefully evaluated – I presented the results in person to the Cancer Committee at Covenant. This conversation took several hours, and included insights on how Covenant is adhering to the guidelines of the MD Anderson Cancer Center, and recommendations for corrective action.

Q. What corrective actions were recommended for Covenant?

A Covenant did a great job at meeting our benchmarks, so we had very few recommendations. They are a prime example of how to diagnose and treat patients the right way, and how to collaborate closely among physicians. The results were excellent in terms of patient care.

We did make some recommendations on a few minor points. We recognize that there are different paths to achieve the same objective, so some local flexibility on the "how" is important. For example, MD Anderson Cancer Center recommends a multidisciplinary planning session for the patient where physicians get together to discuss the patient and agree on a treatment plan. Typically at MD Anderson, this is done on a regular weekly basis, face-to-face in one room – but that set format is easier when all of the physicians are on the same campus. But elsewhere, face-to-face is often replaced with phone conversations and email. So while Covenant didn't handle this exactly how we would, they clearly achieved the correct result. So we had a conversation with Covenant recommending that they include on the patient's chart a statement that multidisciplinary planning took place, list the methodology, and list the physicians involved and the planned course of action.

About Dr. Dempsey: *Before joining the MD Anderson Physicians Network, Dr. Dempsey served as Professor, Diagnostic Radiology, Division of Diagnostic Imaging at MD Anderson Cancer Center. He also served as Section Head of Breast Imaging within the Breast Cancer Center. Prior to coming to MD Anderson, Dr. Dempsey was at the University of Alabama Medical Center where he was Chief of Outpatient Radiology and Section Chief of Breast Imaging. Dr. Dempsey has published 70 peer-reviewed journal articles and five book chapters.*

Q. What feedback are you getting from physicians?

A. Physician feedback has always been very positive. They tell me that one of the greatest resources with certification are the Peer-to-Peer consultations they can have with MD Anderson faculty experts. They simply go to a website portal to ask for help, and then get referred to an expert faculty member at MD Anderson who specializes in that type of cancer. In most instances, they get a personal one-on-one phone call within 36 hours or less. This consultation doesn't cost either the patient or physician any money, but adds a lot in terms of decision-making and confidence. When lives are at stake in complex cases, it's always reaffirming to get a prompt validation from another expert, without a lot of waiting for the call or paperwork.

Q. What is the value of this study to the community?

A. The people of Saginaw should understand that Covenant really is a special institution with intelligent, well trained and truly caring people. For the most part, with very few exceptions, community members are receiving cancer treatment care equal to that which they would receive if they travelled to MD Anderson Cancer Center in Houston, Texas.

Before Covenant became certified, many of the residents did indeed have to travel for treatment, but now they don't. Especially with the affirmation of the Concordance study, we are very confident that patients of physicians who participate in our program are receiving care comparable to MD Anderson. Those physicians who participate in the program wear a pin to show their alliance to MD Anderson standards, which gives patients both confidence and peace of mind.

For more information, please contact Jackie Tinnin, Administrative Director of the Covenant Cancer Care Center at 989.395.1056 or jtinnin@chs-mi.com.

NATIONAL HEALTH AWARENESS EVENTS

September

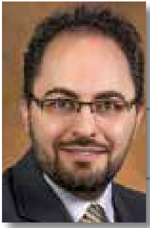
- Prostate Cancer Awareness Month
- Childhood Cancer Awareness Month
- National Suicide Prevention Month

October

- National Breast Cancer Awareness Month
- National Dental Hygiene Month
- Domestic Violence Awareness Month
- Monday, October 2nd: Child Health Day

November

- American Diabetes Month



Have You Heard of Eosinophilic Esophagitis?

GUEST AUTHOR
Dr. Anas Bitar, Pediatric Gastroenterologist

Eosinophilic esophagitis (EoE) – also known as allergic esophagitis – is a relatively new condition that is increasingly appearing in both the pediatric and adult gastrointestinal (GI) world, and many physicians are still not fully aware of it.

Specifically, EoE is a chronic, immune/antigen-mediated, esophageal disease in which the walls of the esophagus stiffen. As a result, solid foods are difficult to pass through the esophagus and into the stomach, causing digestive distress.

This inflammatory condition is more common in Caucasian males, in urban as opposed to rural settings, and in cold, dry zones versus tropical zones. There is a strong association of EoE with food and environmental allergies, asthma, atopic dermatitis and celiac disease. Further, some people are genetically more likely than others to develop eosinophilic esophagitis.

History

EoE has been identified only in the past two decades but is now considered a major cause of gastrointestinal disease. The growing incidence of EoE may be partly due to increased recognition of the disorder and greater availability of upper endoscopy testing. However, population-based studies have supported an unrelated growth rate that is parallel to the increase in asthma and allergy conditions.

EoE is considered a relatively new disease with a sharp *increase* in its incidence.

Diagnosis

Since the symptoms of EoE are not specific, the diagnosis is often missed. In one study, the median delay in diagnosis was six years. In children especially, this delay can have long-term consequences related to their development.

Complications of untreated cases include:

- Scarring and stricture of the esophagus
- Recurrent episodes of food impaction
- Spontaneous esophageal perforation (Boerhaave syndrome)
- Esophageal perforation following endoscopy (occasionally)

Diagnosis of EoE is based on symptoms, endoscopic appearance and histological findings. If an eight-week treatment with a proton pump inhibitor (PPI) shows no response or relief, a specialist should perform an upper endoscopy. In addition, esophageal biopsies and gastroesophageal reflux disease (GERD) should be ruled out.

Diagnostic tests and workup include:

- **Upper endoscopy:** Endoscopic findings include horizontal rings (“feline” esophagus), vertical (linear) furrows, mucosal edema, strictures (particularly proximal strictures), and whitish spots (representing eosinophilic micro-abscesses). A normal-looking esophagus does not rule out EoE.
- **Esophageal biopsies/histology:** Biopsies are obtained from distal and proximal esophagus (two to four biopsies from each part) after at least two months of treatment with a PPI. An increased number of eosinophils (>15 eosinophils per high power field “400x”) that is limited to the esophagus supports a diagnosis of EoE.
- **Barium esophagogram:** This may help identify anatomic abnormalities and provide information on the length and diameter of strictures.
- **Laboratory tests:** There are no serum markers for EoE. However, up to 60% of patients with EoE will have elevated serum IgE levels.

Symptoms

EoE was originally thought to be a childhood disease, but now is known to be common in adults as well. That said, the symptoms differ somewhat.

Younger children present with:

- Feeding difficulties (median age 2)
- Vomiting (median age 8)
- Abdominal pain (median age 12)
- Failure to thrive and poor growth

Adults and teenagers frequently present with the following:

- Dysphagia (problems swallowing) with solid food
- Food impactions or esophageal food bolus obstruction
- Chest pain or heartburn that does not respond to antacids

Treatment

EoE is considered a chronic relapsing disease. Most patients will require ongoing treatment to control their symptoms, and should improve with appropriate therapies. Treatment involves one or more of the following:

- **Dietary therapy:** Although difficult for patients and families to implement, and while there is a possible relapse upon discontinuation of the diet, this is the first-line treatment for EoE in children and motivated adults. Food elimination (testing-directed or empirical) and elemental diets decrease allergen exposure. An experienced allergist and registered dietician will assist in the evaluation of food allergies, guide dietary therapy, and identify and treat extra-esophageal atopic conditions.
- **Pharmacologic therapy:** This treatment includes:
  - Acid suppression to treat GERD, which may mimic EoE, coexist with it or contribute to it.
  - Glucocorticoids (topical or systemic) to decrease esophageal inflammation, but symptoms often recur when steroids are discontinued.
- **Esophageal dilation:** This treatment is for patients with high-grade strictures or who fail conservative therapy. It is only effective for relieving dysphagia, and has no effect on underlying inflammation.

Note: In patients undergoing treatment, the lack of symptoms does not reliably predict the absence of biologic disease activity.

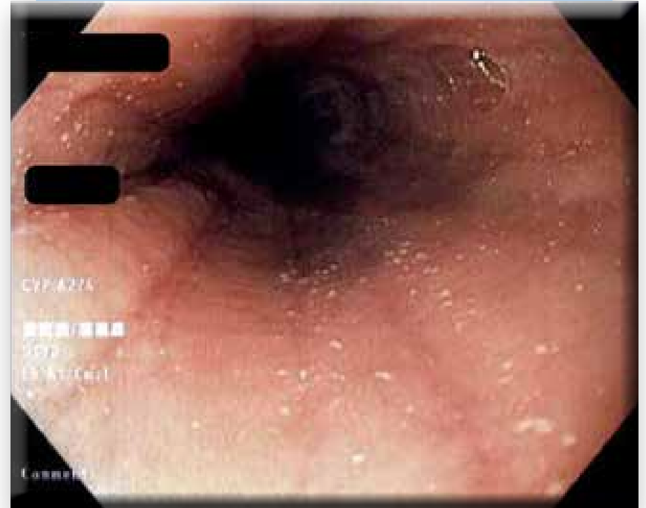
Summary

EoE is considered a relatively new disease with a sharp increase in its incidence. While diagnosis and treatment can improve symptoms, there is still limited data to validate treatment plans and long-term prognosis.

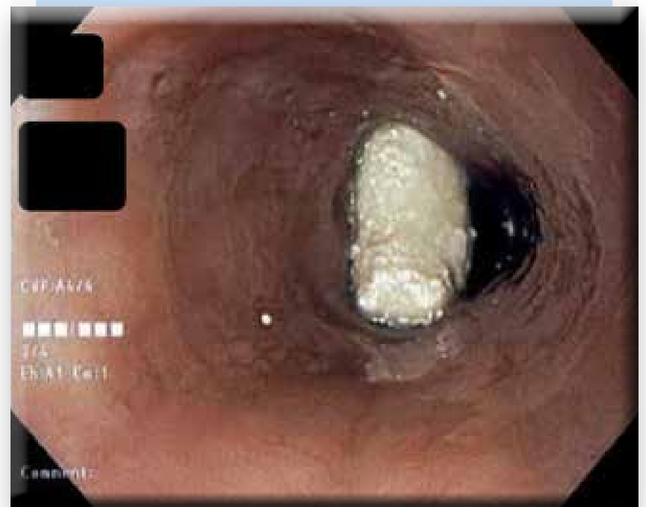
EoE presents with different yet nonspecific symptoms in children and adults, based on age of presentation. Early diagnosis is critical to prevent complications such as esophageal stricture and spontaneous perforation, and to ensure normal development in children.

Any patient with upper GI symptoms (dysphagia, history of food impactions, heartburn, vomiting, upper abdominal pain) who is not responsive to PPI treatment, should trigger a referral to a specialist for diagnostic testing.

For more information about EoE symptoms, please contact Dr. Bitar at 989.583.7076 or abitar@chs-mi.com.



Endoscopic appearance of eosinophilic esophagitis include edema, vertical furrows and whitish spots of the esophagus.



Esophageal stricture with pill impaction.

Stopping Prescription ODs

GUEST AUTHOR

Dr. Matthew Deibel, Emergency Department Medical Director

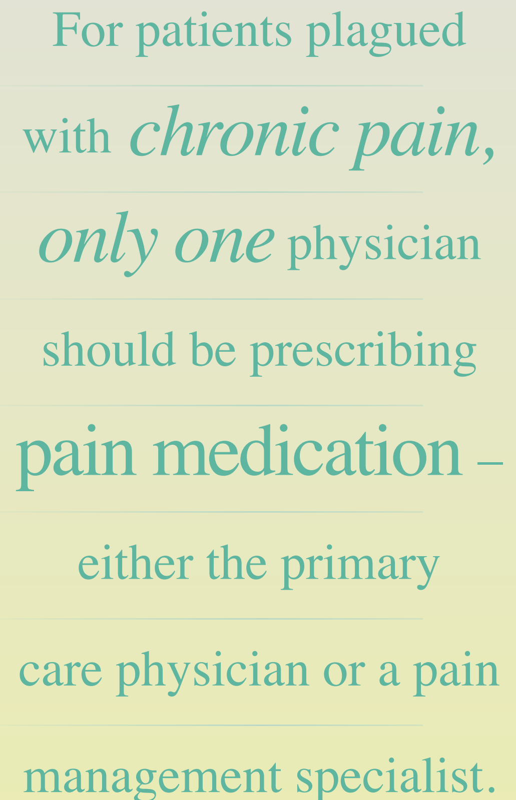
According to the Centers for Disease Control, nearly 15,000 Americans die every year from overdoses (ODs) of prescription narcotics. This statistic exceeds the death toll for heroin and cocaine ODs combined, and has spurred medical facilities nationwide to adopt stricter protocols for managing chronic pain.

This year, the Emergency Care Center at Covenant HealthCare sent new pain management guidelines to employed and affiliated physicians by email and hard copy. This article provides an important reminder about those protocols, and contains information that can help all of us reverse the prescription OD trend.

More Meds ≠ Less Pain

Over 10 years ago, healthcare institutions were asked to be more aggressive in treating pain. Today, despite a tripling of prescription narcotics (and ODs), surveys show NO change in the amount of pain that Americans report. This demonstrates a point of diminishing returns in which more medication doesn't necessarily mean less pain. As you likely know, chronic pain patients who take narcotics on a regular basis actually become more sensitive to pain and require greater doses to dull it.

Unfortunately, the public has now come to expect that they should not have pain with anything. As physicians, we need to reset that expectation through approaches that make pain more tolerable rather than trying to eliminate pain entirely.



One Doctor, One Patient

For patients plagued with chronic pain, only one physician should be prescribing pain medication – either the primary care physician (PCP) or a pain management specialist. If multiple sources are prescribing, there's a temptation for the patient to "doctor shop" and get more pain medication than is safe to use. Having just ONE prescriber will help minimize addiction and inappropriate opiate use.

The Emergency Department's Role

The Emergency Department (ED) is often the first stop for patients experiencing severe pain due to trauma, acute disease or even chronic pain flare-ups. The ED is also where most ODs arrive – so it sees first-hand the effect of overuse, even though the ED accounts for only 4% of opiate prescriptions.

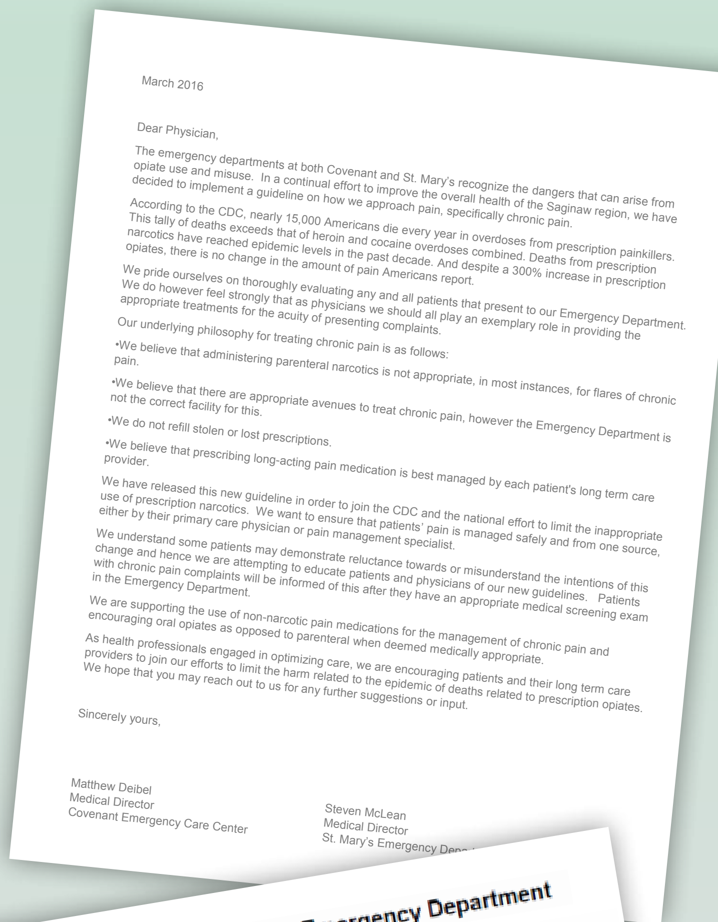
Even so, the ED has stepped up efforts to be part of the solution by reducing patient risk. For trauma and acute disease patients, the ED will prescribe narcotics only as necessary for acute pain. For chronic pain patients, however, narcotics are avoided in favor of non-opiate muscle relaxers and anti-inflammatories. This is because chronic pain patients already have a history of using prescription narcotics and for their safety, refills are best handled by their PCP or pain management specialist. If narcotics are deemed necessary, the patient is prescribed medication for just a few days until their doctor can be seen, and only after their prescription history has been reviewed.

Community Health

The pain management protocol described above has been jointly adopted by Covenant HealthCare and St. Mary's of Michigan, and is also being adopted by MedExpresses and other Saginaw healthcare facilities to protect the health and safety of the Saginaw community. If you have not received a copy of these protocols, see the contact details below.

Meanwhile, as with any change, acceptance by patients will take time. Together, however, healthcare professionals can accelerate acceptance by supporting the new protocols and educating patients about safer pain relief options.

For more information, contact Dr. Deibel at 989.583.6022 or mdeibel@chs-mi.com.



March 2016

Dear Physician,

The emergency departments at both Covenant and St. Mary's recognize the dangers that can arise from opiate use and misuse. In a continual effort to improve the overall health of the Saginaw region, we have decided to implement a guideline on how we approach pain, specifically chronic pain.

According to the CDC, nearly 15,000 Americans die every year in overdoses from prescription painkillers. This tally of deaths exceeds that of heroin and cocaine overdoses combined. Deaths from prescription narcotics have reached epidemic levels in the past decade. And despite a 300% increase in prescription opiates, there is no change in the amount of pain Americans report.

We pride ourselves on thoroughly evaluating any and all patients that present to our Emergency Department. We do however feel strongly that as physicians we should all play an exemplary role in providing the appropriate treatments for the acuity of presenting complaints.

Our underlying philosophy for treating chronic pain is as follows:

•We believe that administering parenteral narcotics is not appropriate, in most instances, for flares of chronic pain.

•We believe that there are appropriate avenues to treat chronic pain, however the Emergency Department is not the correct facility for this.

•We do not refill stolen or lost prescriptions.

•We believe that prescribing long-acting pain medication is best managed by each patient's long term care provider.

We have released this new guideline in order to join the CDC and the national effort to limit the inappropriate use of prescription narcotics. We want to ensure that patients' pain is managed safely and from one source, either by their primary care physician or pain management specialist.

We understand some patients may demonstrate reluctance towards or misunderstand the intentions of this change and hence we are attempting to educate patients and physicians of our new guidelines. Patients with chronic pain complaints will be informed of this after they have an appropriate medical screening exam in the Emergency Department.

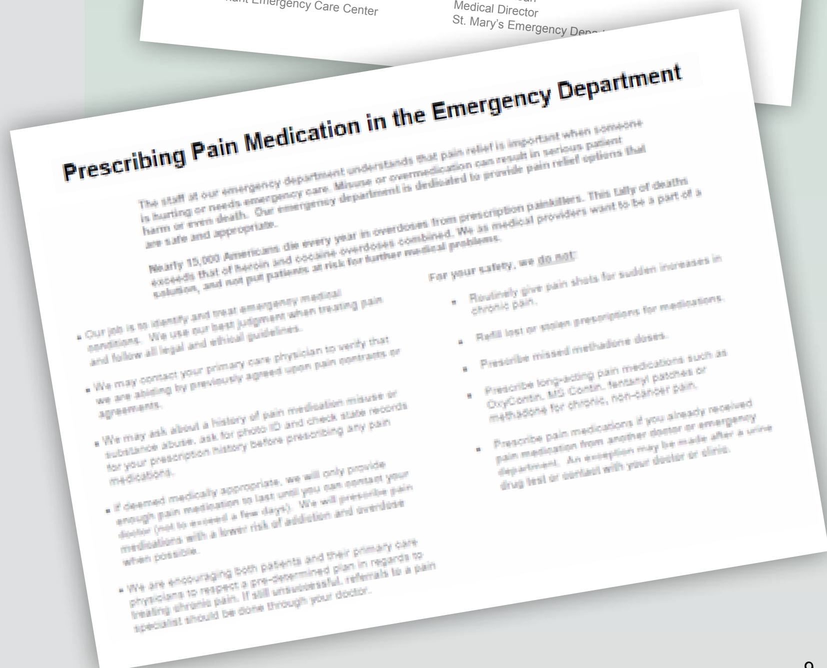
We are supporting the use of non-narcotic pain medications for the management of chronic pain and encouraging oral opiates as opposed to parenteral when deemed medically appropriate.

As health professionals engaged in optimizing care, we are encouraging patients and their long term care providers to join our efforts to limit the harm related to the epidemic of deaths related to prescription opiates. We hope that you may reach out to us for any further suggestions or input.

Sincerely yours,

Matthew Deibel
Medical Director
Covenant Emergency Care Center

Steven McLean
Medical Director
St. Mary's Emergency Depa



Prescribing Pain Medication in the Emergency Department

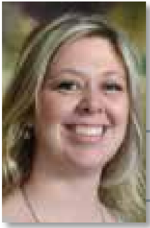
The staff at our emergency department understands that pain relief is important when someone is hurting or needs emergency care. Misuse or overmedication can result in serious patient harm or even death. Our emergency department is dedicated to provide pain relief options that are safe and appropriate.

Nearly 15,000 Americans die every year in overdoses from prescription painkillers. This tally of deaths exceeds that of heroin and cocaine overdoses combined. We as medical providers want to be a part of a solution, and not put patients at risk for further medical problems.

- Our job is to identify and treat emergency medical conditions. We use our best judgment when treating pain and follow all legal and ethical guidelines.
- We may contact your primary care physician to verify that we are abiding by previously agreed upon pain contracts or agreements.
- We may ask about a history of pain medication misuse or substance abuse, ask for photo ID and check state records for your prescription history before prescribing any pain medications.
- If deemed medically appropriate, we will only provide enough pain medication to last until you can contact your doctor (not to exceed a few days). We will prescribe pain medications with a lower risk of addiction and overdose when possible.
- We are encouraging both patients and their primary care physicians to respect a pre-determined plan in regards to treating chronic pain. If still unsuccessful, referrals to a pain specialist should be done through your doctor.

For your safety, we do not:

- Routinely give pain shots for sudden increases in chronic pain.
- Refill lost or stolen prescriptions for medications.
- Prescribe missed methadone doses.
- Prescribe long-acting pain medications such as OxyContin, MS Contin, fentanyl patches or methadone for chronic, non-cancer pain.
- Prescribe pain medications if you already received pain medication from another doctor or emergency department. An exception may be made after a urine drug test or contact with your doctor or clinic.



Shhhhh! Patients Healing

GUEST AUTHOR
Christin Tenbusch, Patient Experience Administrator

As healthcare professionals, we all know how noisy a hospital can be –people talking, alarms clanging, TVs blaring, pagers ringing, wheels squeaking, phones ringing, elevators whooshing and equipment buzzing. That's tough when you are a patient trying to recuperate or a physician trying to concentrate!

The Consequences of Noise

Plain and simple, a growing body of research is showing that noise can harm patients and interfere with the healing process. It can also distract healthcare professionals from the task at hand, possibly increasing the likelihood of medical errors. Noise is stressful on young and old alike: loud neonatal units could delay development of premature babies, while heart patients may need to be rehospitalized later.

The Benefits of Quiet

As a result, hospitals nationwide are taking action to reduce noise levels to ensure optimal patient healing, clinical outcomes and satisfaction. It's shown that more peace and quiet could also require less sedation and result in shorter hospital stays. It can also improve a hospital's reputation because noise is a publicly reported quality measure for U.S. hospitals, and according to CMS Hospital Compare (HCAHPS survey), only 50% of patients report quiet rooms at night.

Changing the Culture

Outside of structural solutions such as noise dampening, the biggest way to fight noise is to change the hospital culture, which basically means training people to be quiet. You may have seen, for example, the Quiet Movement at Covenant HealthCare, which was implemented based on patient feedback. This movement was driven by two key findings:

1. One of the highest trending comments on patient surveys at Covenant was excessive facility noise.
2. Covenant only scored in the sixth percentile to the HCAHPS question: "How often was the area around your room quiet at night?"

Alarmed by these findings, a team of Covenant employees assessed the hospital's current state in 2015. That exercise revealed that that the decibel level in various units was between 60-70 dB. This is *twice* the level recommended by the World Health Organization (WHO), which is 35 dB during the day, 30 dB at night, and no higher than 40 dB overall.

The team also identified the noisiest sources of noise – the biggest being human voices – and is implementing a strategy to improve the "quietness" of the organization. While achieving library-level quiet is impossible given the activities of a hospital, creating a much quieter culture is well within the realm of possibility.

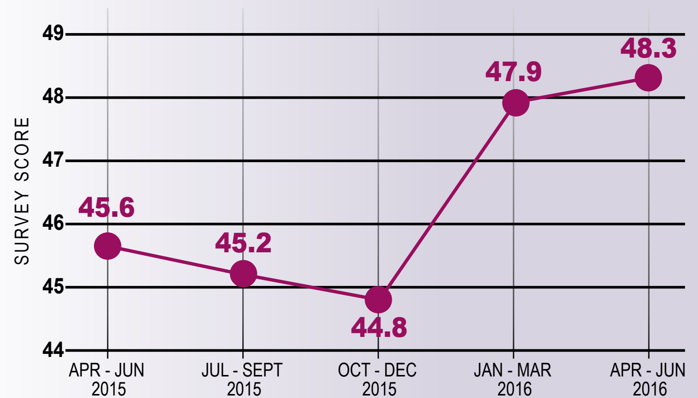
The Prescription for "Quiet"

Florence Nightingale once wrote that unnecessary noise is "the most cruel absence of care which can be inflicted either on sick or well." Achieving a quieter hospital requires everyone's participation and awareness. A few tips for medical professionals include:

- Avoid cell phone discussions or loud conversations at the nurse's station.
- When conversing in a more public area, talk quietly.
- Put pagers on vibrate.
- Use a headset for electronic devices.
- Respect the patient's need for rest and quiet.
- Pretend you are in a church, theater, library or classical concert.

Other patient-related actions at Covenant include:

- Posting "quiet signs" in the unit to encourage anti-noise efforts.
- Proactively asking patients to lower television volumes and/or use ear buds provided by the hospital.
- Limiting visitors at night and keeping conversations quiet.
- Promoting respect for roommates in semi-private rooms.
- Establishing "quiet times" between nursing rounds to minimize noise on the units (2-4 pm or 3-5 pm).
- Dimming lights in the evening to promote softer talk.



Anti-Noise Progress

While it takes time to effect change, things are starting to quiet down as shown in the Noise Reduction Progress chart above. The trend is favorable, but much more work needs to be done not just at Covenant, but at hospitals nationwide as we all struggle for ways to reduce noise and thus make our hospitals, much more hospit*able*.

For more information, contact Christin Tenbusch at 989.583.7491 or ctenbusch@chs-mi.com.

A while ago, an idea was bandied about – what about writing a humor column for *The Covenant Chart*? I liked it, so why not? Immediately, unfunny times hit. Thankfully no tragedies, just the daily work of patient care. But no slapstick, no monkeys, no clowns, nothing. I had to confess the humor mill had dried up.

Then it hit me. Should I allow the daily pressure of medicine to take humor – maybe even joy – out of my daily life? Finding a bit of happiness and humor in each day would certainly make life sweeter, and probably rub off on my patients.

So I decided to put on my big boy skivvies, man up and find a reason to laugh. Life's just better that way. So I set out to find and appreciate something funny. "Be careful what you ask for," I've always been told.

In short order, it happened … the dreaded cell phone falling in the toilet on 3 East (pre-void, thank goodness). The holster popped right off my scrubs – the whole shebang, kerplunk, right into the drink. *Code Poo – Cooper 3 East! Code Poo – Cooper 3 East! Code Poo – Cooper 3 East!*

I am impressed that my reflexes, honed from years of playing hockey goaltender, are still intact. Like a cobra, my hand shot into the still- clean toilet water and rescued the soggy, dripping mess. Yuck – what to do now? Why not laugh? It's an absurd situation so I played it up.

Secured in a biohazard bag (the toilet phone's equivalent of the C-collar and backboard), I hustled the patient to the nurse's station, and put it on the counter to be treated like every trauma. (*In your dreams, surgeons would surely retort*.) The nurses laughed and played right along.

"Pad!" I yelled. A blue pad was slapped onto my hand in true OR fashion. *Plop!*

"Gloves!" I shouted. "No kiddo," they said, "you need a whole box." *Slap!*

"Wipes! Toxic, mutagenic, germicidal wipes!" I called. "Sure, but take the whole container," they said. *Plunk!*

By the time we were ready to go, the only thing missing in my extemporaneous OR was the airborne isolation helmet demo'ed at the last Active Medical Staff meeting.

Everybody said, "Put it in rice!" amid giggles and chortles. Yeah, like I have time to call food service and get into the larder. I shouted, like an ER doc. (*In your dreams, ER docs would likely retort*.)

"We've got an accidental drowning, no time for nonsense, we need to save this one STAT!"

"Multiple layer gloving – quick!"

"Wipe, toss, strip down to the next pair of gloves – repeat!"

Glad my internship included general surgery! And on it went, through all the layers of gloves. Finally I yelled, "Nurse, call my cell phone!" In other words, shock the patient. "All clear!" they replied. Tick, tick, tick … the tension mounts, and we hold our collective breath. Brrrriiiiinnnggg! Shouts of joy! We saved it! Not a dry eye in the house!

I am pleased to say that dozens of wipes and several pairs of gloves later, with excellent assistance from the crackerjack, professional RNs on Cooper 3 East, we saved this one. True teamwork. Good humor. Pulling together in a time of crisis, not losing our heads and using the ACLS we've all been taught – Advanced Cellular Life Support (thanks to CMU). Putting the patient first, so to speak. The little (but expensive) fella is good as new. Still has that new porcelain smell too.

I wonder why the nurses didn't want to shake my hand in congratulations, though?

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Is "Bob" Back Again? Continued from page 1.

Turning Things Around

Why some people can cope with serious illnesses and disabilities while others shut down at the very thought of a medical concern is something we may never figure out. Maybe it's partly due to information overload and the side effect of mass media, social media, the Internet, doomsday movies and so on.

We all misinterpret our symptoms on occasion, but if your patient has excessive and unrealistic worries that significantly affect his or her life, maybe it's time to have a gentle discussion to suggest some professional counseling, too.

It also may be helpful to suggest that the patient explore how the mind and spirit interact with the body to make it healthy with positive thoughts, or sick with negative thoughts.

I wish my med school friend could have been more positive; if he was, he might still be here today.

Thank you,

Dr. James Hines
Chief of Staff

Of all patients suffering from *hypochondriasis* about 75% have somatic symptom disorder and 25% have illness anxiety disorder.