



The Sky Is the Limit

*Dr. James Hines
Covenant HealthCare Chief of Staff*

In the fall of 1976, I began my medical studies as a freshman at the Indiana University School of Medicine. At that time, the medical school possessed a 1,500-pound computer by which an object could be manually rotated on a screen! I was intrigued, but wondered how this could ever apply to medicine.

This was before DVD players, cell phones, iPods, iPads, ultrasounds or personal computers of any size, not to mention laptops.

Today, I have a laptop with an electronic medical record (EMR) that goes with me into every patient's room. I can look up lab reports, old medical records and studies. Frequently, I pull up an ultrasound scan of a baby or of the female pelvic organs to examine the pictures with the patient and family.

This is so cool, not to mention efficient since I can complete the entire patient encounter, including ordering tests and treatment, right in front of the patient. Plus, any medication prescribed goes to the pharmacy electronically during the visit. No more writing a prescription on a pad of paper.

Patients come into the office and are given an electronic tablet instead of a clipboard. Many patients email questions for our staff to answer electronically. We are currently setting up a system for patients to schedule their own appointments.

What's next? Well, the sky is the limit. Telemedicine technologies are not just on the horizon, but are a reality. Covenant VirtualCare, for example, enables patients to have a virtual face-to-face visit with a physician via smartphone, computer or tablet for certain types of conditions. This avoids waiting rooms, reduces urgent care visits, saves money and more.

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The doctor-patient
relationship

will remain

paramount

to the healing process as

we continue to provide

patient-centric

care.



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Collaborating To Improve Clinical Documentation

GUEST AUTHOR

Dr. Glenn Cipullo, Medical Director of Clinical Utilization, and Rose Ann Deford, RN, Clinical Documentation Specialist

To paraphrase Dr. Lawrence Weed at his Emory University lecture in 1971, accurate and complete clinical documentation is a core reflection of quality patient care. However, it must be timely and meaningful. For it to be meaningful, it should represent the patient's true clinical status and the necessity of resources provided.

The clinical documentation specialist (CDS) is a knowledgeable and experienced RN whose primary role is to help bridge the gap between the patient's documented clinical status and the coding translation. That said, if correct and high-quality documentation is not provided by the physician, the coded record will not reflect the true complexity of the patient or the scope of services provided.

Clinical Documentation Improvement (CDI) programs are designed to collaborate with physicians to provide the proper documentation, which is then translated into coded data used for:

- Monitoring quality measures and outcomes for Covenant HealthCare.
- Physician profiling and credentialing.
- Research data and disease tracking.
- Utilization of hospital services and appropriate length of stay.
- Organizational budgeting and strategic planning.

Partnering for Success

CDI programs are a partnership between providers and the CDS team. Key goals of the CDI program include:

- Accurate, complete documentation that:
 - Reflects the true medical complexity and quality of care received by patients at Covenant.
 - Is reflected in quality ratings (e.g., a comparison of Covenant against the highly competitive Michigan hospitals having comparative discharge rates).
 - Reflects the appropriate need for utilizing services.
- Compliance with Center for Medicare & Medicaid Services (CMS) guidelines.

The Value of Reviews

To ensure accuracy, the CDS performs concurrent reviews of medical records and may occasionally write a query to the provider to clarify the appropriate clinical documentation. This will help accurately reflect the patient's ongoing medical condition, required need for continued length of stay and the necessity of ongoing hospital services. It is important for physicians to understand this is not to question their medical expertise, judgement or treatment plan, but rather to help ensure medical record accuracy.

The End Result

Organizational success and patient-centric care commitments require a team approach, including collaboration among providers and the CDS team. The end result is a true reflection of the extraordinary care and values delivered at Covenant HealthCare to our patients and the community.

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





The Age of Covenant VirtualCare

Dr. John Kosanovich, Executive Vice President, Physician Enterprise

In the June issue of *The Covenant Chart*, we provided an update about the Telehealth Train, and how healthcare organizations like Covenant HealthCare are starting to jump on board in a big way. Telehealth is critical to the future of medicine, including the ability to provide modern, high-tech care to patients in ways that optimize outcomes and convenience.

Since then, we've held meetings with medical staff to discuss how to best integrate this new technology into our operations while respecting the framework of *Our Covenant*. This led to the launch of a new service: Covenant VirtualCare and the following timeline of activities:

- **October 1, 2016:** Covenant VirtualCare was rolled out to the public with American Well's Online Care Group of U.S. board-certified physicians. They are providing on-demand virtual visits for treatment of low-acuity conditions, diagnosis and if needed, prescriptions. This is an interim period that allows time to train and phase-in Covenant physicians and Covenant PHO independent physicians.
- **January 2017:** The Covenant Medical Group (CMG) will be integrated into this service and trained to provide both on-demand virtual visits and scheduled virtual visits.
- **Soon after CMG training and integration:** Covenant PHO-independent physicians will be trained and brought on board too.

Naturally, there will be questions. For complete transparency, physicians have been – and will continue to be – involved and updated via letters, newsletters, physician meetings and other venues.

A number of subcommittees have been formed, including a clinical subcommittee (see sidebar) led by Dr. Aaron Smith, chief medical informatics officer, to ensure that Covenant VirtualCare clinically upholds our vision to deliver “extraordinary care for all generations.” This means delivering on our goals for patient quality and safety, while collaborating with physicians to ensure Covenant VirtualCare complements their practices and helps drive success.

You are encouraged to get engaged by reading updates, voicing your questions and concerns to Dr. Smith or expressing your interest in participating.

For more information, contact Dr. Aaron Smith at 989.583.6256 or Aaron.Smith@chs-mi.com; or contact Jaime TerBush, Program Administrator, at 989.395.3480 or jaimeterbush@chs-mi.com.



Jaime TerBush is Program Administrator for Covenant VirtualCare. She most recently served as a Covenant Physician Liaison. Expect to hear more from Jaime in the future!

Clinical Subcommittee

- Dr. Aaron Smith (Chair), Chief Medical Informatics Officer
- Dr. John Kosanovich, Executive Vice President, Physician Enterprise
- Dr. Matt Deibel, Medical Director, Emergency Care Center
- Dr. John Georgakopoulos, Medical Director, MedExpress
- Dr. Amjed Aljanabi, Family Medicine
- Dr. Trasi Crumrin, Family Medicine
- Dr. Robert Nettleman, Family Medicine
- Dr. Jorge Plasencia, Family Medicine
- Dr. Ryan Stevenson, Family Medicine
- Dr. Arun Veera, Family Medicine
- Dr. Colleen Linehan, Orthopaedic Surgery
- Dr. Frank Schinco, Neurosurgery
- Frank Fear, Chief Information Officer
- Gayle Biederman, Director, Physician Hospital Organization
- Larry Daly, Director, Planning & Business Development
- Peggy Maine, Director, Revenue Cycle
- Karen Schafer, Director, Physician Relations & Regional Outreach
- Jaime TerBush, Program Administrator, Covenant VirtualCare
- Sherri Davidson, Manager, Health Information Management & Transcription
- Mindy Stokoszynski, Portfolio Manager
- Alex Norton, Lead Senior Applications Analyst, Electronic Medical Record



Balloon Sinuplasty Procedure: Safe and Fast

GUEST AUTHOR

Dr. Jeffrey Milewski, Otolaryngologist / ENT, Valley ENT Associates, PC

For patients suffering from chronic sinusitis or recurring acute sinusitis, a minimally-invasive balloon sinuplasty (BSP) procedure offers excellent relief without the common side effects of traditional sinus surgery. Safe, fast and proven, it has been available since 2006 and is increasing in popularity.

Advantages Over Traditional Surgery

Physicians and patients have historically shied away from traditional sinus surgery which often necessitates the removal of bone or tissue from the nose to improve sinus drainage. This, in turn, requires an OR, general anesthesia and hospitalization and can increase bleeding, scarring, pain and time off from work. Plus, nasal packing is needed to address bleeding and recovery can be one to two weeks.

Conversely, the BSP procedure offers the following advantages:

- It does not require cutting of bone or tissue.
- It can be performed under local anesthesia in the office.
- Bleeding and pain are minimal and nasal packing is not needed.
- Patients can return to normal activity within a few days.

The BSP procedure is proving to be an effective alternative for relieving chronic or recurring sinusitis symptoms. In one study, most patients reported clinically meaningful improvements in sinus symptoms and quality of life two years after balloon sinuplasty¹.

Patient Eligibility

When patients present with chronic sinusitis or recurring acute sinusitis, physicians typically prescribe various nasal sprays and/or antibiotics. Such treatment plans work for most patients. However, if patients are unresponsive to these treatments, quality of life is significantly impaired. They may experience constant headaches, nasal congestion, facial pain, difficulty breathing, loss of smell, sore throats, constant post-nasal drainage, teeth pain, bad breath and more.

Such patients are eligible for the BSP procedure if they are

18 years or older and if they do not present with sinonasal tumors or polyps.

While every medical procedure harbors some risk, BSP carries significantly less risk than traditional sinus surgery and complications are rare. Most insurance companies and Medicare cover the BSP procedure.

Simple and Cost-Effective

The BSP procedure is simple and cost-effective, and is similar to a balloon angioplasty. As shown in the illustrations below:

- A trained ENT uses a flexible balloon catheter to open up blocked passageways so that mucous can drain out and thus relieve pressure.
- There is no cutting or removal of bone and tissue, reducing risk and complications while retaining the integrity of the sinus lining.
- ENTs can perform the procedure under local anesthesia in about 60 to 90 minutes versus the four hours required in an OR for traditional surgery with general anesthesia.

As mentioned, all of the above can help reduce costs, plus the patient can return to work faster.

Taking Action

To date, trained ENTs have treated more than 380,000 patients suffering from chronic sinusitis or recurrent acute sinusitis with the BSP procedure. It is shown to be safe, fast and effective. If you have patients who are unresponsive to nasal sprays, antibiotics and other basic treatments, this minimally-invasive procedure may be just what they need. Consider sending them to an ENT for a thorough evaluation before their symptoms get worse.

For more information, contact Dr. Jeffrey Milewski at 989.799.8620 or jmilewski@outlook.com.

¹Otolaryngol Head Neck Surg., 2008; 139:S38-S46.

Balloon Sinuplasty Procedure

STEP 1



Insert balloon catheter into the blocked sinus.

STEP 2



Inflate balloon to gently expand sinus opening.

STEP 3



Spray saline into sinus to flush out mucus and pus.

STEP 4



Remove balloon after sinuses are open.



Watch Out for Watchman

GUEST AUTHOR

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

If you have patients at risk for stroke due to non-valvular atrial fibrillation (NVAF), then you will want to know about the Watchman™ Left Atrial Appendage (LAA) device. It is specifically designed to help these patients avoid a lifetime of anticoagulants like warfarin, and gives new hope to those who cannot tolerate anticoagulants at all.

Historically, patients who are intolerant to anticoagulants may choose to do nothing or may try anti-platelet medications like aspirin. Unfortunately, trials show that anti-platelets are largely ineffective at preventing stroke in NVAF patients. Therefore, the Watchman innovation is a welcome alternative for reducing the risk of stroke. It is a one-time procedure that could be a lifetime solution.

The Watchman

should be seriously considered

as a unique, alternative therapy

for stroke prevention.

A One-Time Procedure

Over 90% of stroke-causing clots that come from the heart are formed in the LAA, which is located in the upper left chamber of the heart. The Watchman device – which has a meshed, self-expanding umbrella structure – is permanently implanted in the LAA to occlude this structure, allowing blood to pass through while preventing the migration of stroke-causing blood clots. Small fixation bars keep it attached to the LAA wall. In about nine months, heart tissue will cover the device, completely sealing the LAA.

The Watchman procedure is performed under general anesthesia in a cardiac catheterization laboratory, usually in 20-30 minutes. First, the electrophysiologist performs a transesophageal echocardiogram to measure the LAA to determine the size of the Watchman device to implant. Next, the Watchman is delivered to the LAA via a wide-sheathed catheter inserted in a vein in the right leg, and via the heart wall dividing the left and right upper chambers. After the Watchman is placed, contrast agents are used to ensure it is properly positioned.

A Lifetime Solution

The Watchman device has been extensively evaluated in clinical trials including the PROTECT AF trial, the PREVAIL trial, and the Cap and Cap2 registries. The LAA occlusion with Watchman is shown to be:

- Safe and feasible.
- Comparable in efficacy to patients taking anticoagulants for stroke prevention.
- Proven to decrease an NVAF patient's stroke risk by as much as 77%.
- A reasonable alternative to anticoagulant therapy for stroke prevention.
- Indicated for NVAF patients who have documented intolerance or adverse reactions to anticoagulants if they have a CHADS2-VASC score of 2 or more.

NVAF patients benefit from:

- A permanent stroke prevention option and freedom from anticoagulants.
- Freedom from ongoing device monitoring.
- No significant comorbid restrictions, as the device can be implanted in the elderly with great safety.

A Serious Consideration

The Watchman procedure has been performed at Covenant HealthCare since mid-2016, with three to six procedures performed each month with no major complications to date. If your NVAF patients want to stop using anticoagulants or are not suitable candidates for anticoagulation therapy, the Watchman should be seriously considered as a unique, alternative therapy for stroke prevention.

For more information, contact Dr. Asim Yunus at 989.754.3000 or ayunus@mcvi.com. To schedule a patient assessment, contact Deb Best, Covenant Structural Heart Program Coordinator, at 989.583.7171.





Proton Pump Inhibitors, Dementia and Osteoporosis: A Disturbing Correlation

Dr. Todd Richardson, General Surgeon, Mid-Michigan Surgical Specialists, and Chairman of the Department of Surgery

One of great pharmacological advances of the 20th century was the proton pump inhibitor (PPI), as it allows patients with ulcers, gastroesophageal reflux disease (GERD) and other reflux issues to get non-surgical relief of symptoms. Recent data, however, show that PPIs may contribute to osteoporosis and dementia. Consequently the industry is re-examining PPI use and duration, and when surgery may be a more appropriate treatment.

PPI Studies

Typical treatments for GERD include lifestyle changes, antacids and PPIs – with the latter being the most common for addressing and healing esophagitis.

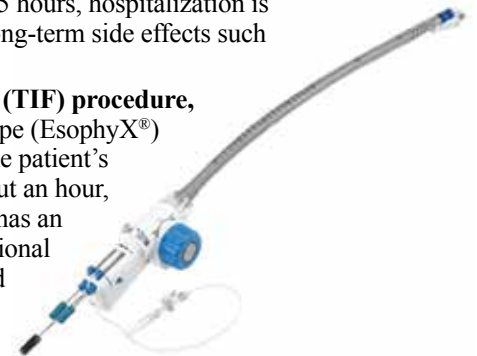
Now that PPIs have been on the market for several years, studies are starting to implicate them as advancing osteoporosis especially in elderly female patients, and increasing the risk of dementia in men and woman. Studies are also revealing that acid reflux is far more prevalent than expected and consequently, so is the use of PPIs.

As a result, the medical community is at a crossroads as to whether: 1) physicians should continue treating GERD with PPIs and if so, for how long, and 2) seriously consider surgical options for patients with severe GERD who are not responding to PPI therapy. This is because such patients are at a higher risk for Barrett’s esophagus and esophageal cancer.

Surgical Options

Fortunately, many surgical options are available. These include:

- **Traditional laparoscopic anti-reflux operations like fundoplication.** In fundoplication, the anti-reflux valve is modified by wrapping the fundus (upper part of stomach) around the esophagus. This stops acidic stomach contents from refluxing into the esophagus and thus reduces painful symptoms. While this approach requires abdominal incisions, it is proven to reduce the need for PPI therapy – with 30% of patients stopping PPI therapy entirely. Patients are wary of this procedure though because it is invasive and thus carries additional risk. Time in the OR is about 1.5 hours, hospitalization is two days and recovery takes 4-6 weeks. Patients may also experience long-term side effects such as bloating, flatulence and swallowing issues.
- **The newer minimally-invasive transoral incisionless fundoplication (TIF) procedure, and other laparoscopic procedures.** TIF uses a special esophageal scope (EsophyX®) to reconstruct the anti-reflux valve. TIF is performed entirely through the patient’s mouth, so no scarring or incisions are required. The procedure lasts about an hour, hospitalization is only one day and recovery is less than one week. TIF has an excellent safety profile and fewer side effects and discomfort than traditional anti-reflux surgery – along with equivalent results. It is found to succeed in 83% of patients, with more than 18,000 procedures performed worldwide. Patients may experience some short-term discomfort, but long-term side effects are rare.



The surgical choice depends on the patient. TIF, for example, can only be used for patients having a hiatal hernia that is 2 cm or less and a 32 BMI or less. Severe GERD – or patients who are not TIF candidates – should continue to be treated with conventional anti-reflux surgery.

GERD SURGICAL OPTION COMPARISON¹

PROCEDURE	OR TIME	HOSPITALIZATION	RECOVERY
Traditional laparoscopic anti-reflux operations	1.5 hours	2 days	4-6 weeks
Transoral incisionless fundoplication procedure	1 hour	1 day	Under 1 week

¹Table reflects typical results

Studies are starting to implicate PPIs as advancing osteoporosis or increasing the risk of dementia.

Next Steps

While GERD has become a mainstream term, it requires serious attention. It can be extremely painful, mimic heart attacks (sending people to the ER), and if not properly treated, can lead to other serious problems.

Research on the disturbing correlation between PPIs and osteoporosis and dementia continues. Meanwhile, physicians should not prescribe PPIs long-term for GERD patients. Patients with continued acid reflux problems should be evaluated by a specialist to determine the severity of their condition. Surgery may be considered if patients are not responding to PPIs, they have been on PPIs for several years, or they have large hiatal hernias.

For more information, contact Dr. Todd Richardson at 989.790.4855 or judiths@mmsurgery.com.



FAST FACTS

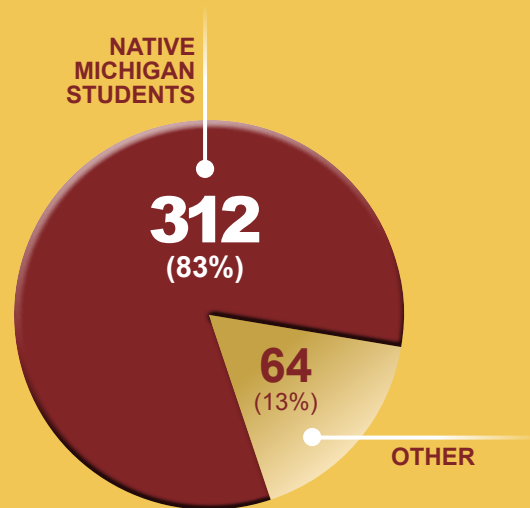
Fourth Class CMED

With the inaugural class of 64 CMU College of Medicine (CMED) students in its final year of studies, new fourth-class students started their journey in August. Here are some fast facts about the fourth class:

- CMED is brought up to capacity for the first time since it was established in 2009.
- The class was selected from an applicant pool of 4,854 – our largest candidate pool yet.
- Of the 104 students admitted, 80 – or 77% – are from northern and central Michigan, supporting the goal to have local talent support local populations in Michigan and the Midwest.
- It represents graduates from 48 colleges and universities, with Michigan universities among the top five.
- 15% of enrollees are minorities plus two National Health Service Corps scholars.

Today, the number of total enrolled students in CMED is 376, with 83% being Michigan natives. The first two years in CMED are spent on CMU's main campus in Mount Pleasant in a modern, 60,000-square-foot facility. The next two years are spent at the new 46,000-square-foot College of Medicine educational facility in Saginaw and in clerkships across the state – including hospital clerkships at Covenant HealthCare and St. Mary's of Michigan.

2016 CMED ENROLLED STUDENTS





Surviving Critical Illness: The Role Of Long-Term Acute Care Hospitals

GUEST AUTHORS

Dr. Samuel Hammerman, Chief Medical and Quality Officer for Select Medical, and
Matt Campbell, CEO for Select Specialty Hospital - Saginaw

Technological advancements in the intensive care environment have increased the number of patients surviving acute catastrophic illness. Some of these patients become chronically critically ill and require ongoing acute nursing and medical care that extends beyond the usual length of stay (LOS) in a short-term acute care environment. This extended acute care may be provided in specialized Long-Term Acute Care Hospitals (LTACH). Locally, an organization called Select Specialty Hospital - Saginaw fulfills that need with its licensed 32-bed LTACH located on the eighth floor of Covenant HealthCare, Harrison Campus.

Using Select Specialty as an example, this article provides an overview of LTACH facilities and the value they bring to hospitals and patients.

This level of care compares equally to a step-down unit within the short-term acute care hospital space. However, confusion remains about the care LTACHs provide and how they differ from other types of post-ICU settings. An LTACH is a fully functioning acute care hospital, as opposed to a skilled nursing facility or inpatient rehabilitation facility. It provides the highest level of clinical expertise and care for very fragile patients with high-acuity needs.

The LTACH Patient Profile

Patients requiring acute dialysis, liberation from mechanical ventilation, complex wound management, management of one or more infectious disease processes, or frequent administration or adjustment of intravenous medications may be eligible for admission to an LTACH. Other conditions range from neurological and renal disorders to cardiac conditions and post-trauma care.

Referring Patients to LTACH

Clinical liaisons, skilled in the assessment of chronically critically ill patients, work with short-term acute care hospital case management teams to assess clinical needs, coordinate admission and assure continuity of care between settings.

The LTACH Care Environment

LTACH care is administered through an interdisciplinary clinical team that manages the patient's complex medical issues (see sidebar). Together, they work closely on a treatment plan that encompasses the patient's and family's goals for healing. The team focuses on continued medical stabilization, management of critical drips, optimizing respiratory status and facilitation of functional recovery. A number of technologies are used to assess and sustain care, including ventilators, EKG monitors and intravenous equipment, and to manage acute physiologic decompensation such as respiratory failure, sepsis and acute pulmonary edema. Interventions can also be performed at the facility, from central venous catheter insertion and percutaneous endoscopic gastrostomy tube insertion to bronchoscopy and colonoscopy.

The ultimate goal in caring for these complex patients is the restoration of normal function with an emphasis on mobility and weight bearing, effective nutrition, management of current organ dysfunction and prevention of additional complications. These healing and recovery protocols are difficult to achieve. LTACH clinicians have specialized knowledge of chronic critical illness which may help improve the likelihood of functional outcomes.



An LTACH is a *fully functioning acute care hospital*. It provides the highest level of clinical expertise and care for very fragile patients with high-acuity needs.

LTACH Defined

LTACHs were established in the 1980s as fully functioning acute care hospitals with their own separate nursing staff, pharmacists, and teams of respiratory, physical, occupational and speech therapists. The medical staff is often comprised of physicians practicing within the community systems that are separately credentialed within the LTACH. These characteristics differentiate LTACHs from skilled nursing facilities or inpatient rehabilitation hospitals allowing for care of the highest acuity patients.

LTACH Interdisciplinary Care Team

LTACH care is administered through an interdisciplinary clinical team that manages the patient's complex medical issues.

The Care Plan and Discharge Process

Patients and their families who have experienced an unexpected prolonged hospital stay present a unique set of challenges for care. They are often hesitant to leave the intensive care unit (ICU) environment and require reassurance that their care needs will be met in an LTACH. Communication and collaboration are intrinsic to the patient's expectations and experience. Goals are set with the patient and their families during care conferences. These sessions allow the clinical team, patient and family to discuss and agree on care delivery and a discharge plan.

The transition of a patient from the ICU to an LTACH is an enormously important step in their healing. While some patients may be discharged home, many will transition to inpatient rehabilitation, skilled nursing or hospice care. The decision to transfer to the next level of care is based on the patient's medical stability and potential for rehabilitation.

Ultimately, the goal of any post-acute venue is to return patients home with a functional recovery. In comparison to other venues, LTACHs have a lower readmission risk and higher likelihood of discharge to home for patients suffering from prolonged mechanical ventilation.

For more information, contact Matt Campbell at 989.583.4667 or MatJCampbell@selectmedical.com.

Select Specialty Hospital (SSH) - Saginaw

AGGREGATE DATA SEPTEMBER 2014 - AUGUST 2016¹

As shown, SSH - Saginaw is delivering quality higher than the National Healthcare Safety Network benchmark and Select Medical averages.

Quality Measure	SSH – Saginaw Events	SSH – Saginaw Rate	Select Medical Average ²	NHSN Benchmark ³
CLABSI Rate (Central Line-Associated Blood Stream Infection)	6	0.46	0.79	0.8
CAUTI Rate (Catheter-Associated Urinary Tract Infection)	10	1.21	1.37	1.8
Falls with Injury Rate	3	0.16	0.49	
C. diff Hospital Acquired Infection Rate	15	7.98	8.76	

¹Based on 434 discharges.

²Based on 106 hospitals.

³Based on 2014 national data from 501 LTACH reporting to the Center for Disease Control's National Healthcare Safety Network.

TEAM

Team Members

- Physicians who are often skilled at endotracheal intubations and can manage rapid response calls and cardiopulmonary arrest
- Registered nurses (certified in acute cardiac life support)
- Wound care nurses
- Certified nurse assistants
- Physical, speech, respiratory and occupational therapists
- Dietitians
- Case managers

GOALS

LTACH Care Goals

- Progressive mobilization
- Optimizing nutrition
- Enhancing communication
- Early liberation from mechanical ventilation
- Reduction of hospital-acquired conditions – a key focus of LTACH

Note: Dr. Ayesha Khan has recently accepted the position of Medical Director of Select Specialty Hospital - Saginaw.



A Saving Grace: Senior Emergency Rooms

GUEST AUTHOR

Dr. Risty Kalivas, Emergency Medicine Physician and Physician Administrator of Covenant Senior Care

Today's baby boomer generation is placing extra demands on the healthcare system, including the ER. Take a minute to learn about trends in senior ER care that are designed to improve outcomes for seniors while reducing costs.

The Trend

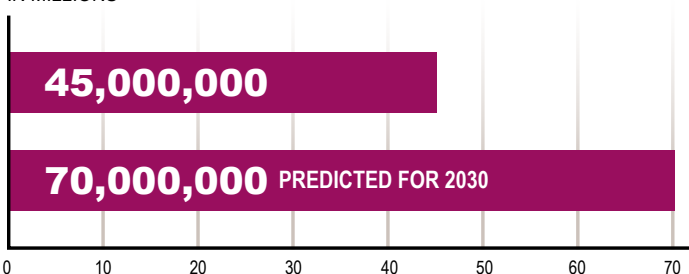
The population of seniors in the United States has been growing by leaps and bounds since 2011, when the first baby boomers reached age 65. Today, this group includes 45 million people or approximately 13% of the U.S. population. In 2030, it will grow to 70 million or 20% of the population. There is no question that seniors will need a lot of healthcare – especially those with troubling health conditions.

In response, a growing number of hospitals have been gradually adding specialized senior – or geriatric – services to their menu of capabilities. ERs are a case in point and today, about 100 ERs in the U.S. have a section designated for senior patients. This is in addition to traditional sections dedicated to pediatrics, trauma, OB/GYN and mental health patients.

While senior ERs got their start about 10 years ago, not all have been successful as hospitals tried to implement various models. Today, though, best practices are available to ensure success. Key goals are to enhance the patient experience, improve outcomes and reduce readmissions, errors and costs.

Covenant HealthCare is among those hospitals seeking to implement best practices and has a senior care facility under construction in its Emergency Care Center (ECC). A soft launch occurred in the fall, and a formal opening is anticipated in the first half of 2017.

U.S. BABY BOOMERS 65 YEARS OF AGE AND OLDER
IN MILLIONS



What a Senior ER Looks Like

Many of today's senior ERs are being built upon best practices and research and will typically address senior-specific needs for:

- Appropriate screening and triage.
- Geriatric-trained ER providers and staff – including physicians, nurses and residents.
- Senior-friendly rooms that address physical challenges, equipment needs, vision problems and hearing issues.
- Visual and hearing devices, which will be available during treatment for patients who need them.
- Calendars and clocks with larger letters and numbers.
- Better gurney mattresses to reduce pressure points and avoid skin breakdown.
- Social workers to help with various needs, such as medical benefits, home care, nursing home care, hospice or palliative care.

Enhanced Medical Protocols

Senior ERs will also address special needs for medical screening and medication reconciliation. At Covenant, for example:

- Medical screening will occur the moment the patient enters the ER to identify those at high risk.
- Nationally recognized screening tools will be used such as the confusion assessment method (CAM) as well as other screening tests. This will tie into screening methods already used at Covenant, such as the CAM-ICU screening tool.
- Other screening includes whether a patient lives alone and/or has a qualified caregiver; assessing those who may have difficulties with activities of daily living (ADL) such as walking, bathing and making meals; evaluating for signs of elder abuse; and determining patients at high risk for falls, especially those who have fallen in the last 30 days.

In addition, improved medication reconciliation will help reduce iatrogenic complications, delirium and confusion, which can lead to a myriad of serious issues. A pharmacist or pharmacy technician will be in the Senior ER to review medications, adjust dosing as needed, keep the medication lists up to date, and look for drug-drug interactions and inappropriate medications for this patient population, such as sedatives and NSAIDs.

Improving the Care Connection

One huge gap at many hospitals is the hand-over from hospital discharge to continued care. There is a concerted effort to work more closely with extended care facilities and local nursing homes to understand why a patient was sent in the first place, and what the new treatment plan should be after discharge – and if the facility can handle that treatment.

Examples of how Covenant is improving the care connection include:

- Developing a system of transfer envelopes to standardize the process and cut down on errors and misunderstandings.
- Implementing a multi-disciplinary effort to better understand the capabilities of each care facility and if they can meet the patient's needs after discharge.

Such actions should enhance overall care and reduce 30-day readmissions.

Summary

There is a lot of work to be done as healthcare providers strive to meet the specific needs of a growing senior population. Senior ERs can be the saving grace for many elderly patients who need specialized treatment. This, in turn, can improve outcomes and quality of life while reducing errors and costs. Take a moment to explain this trend to the senior patients in your practice so they are informed and aware.

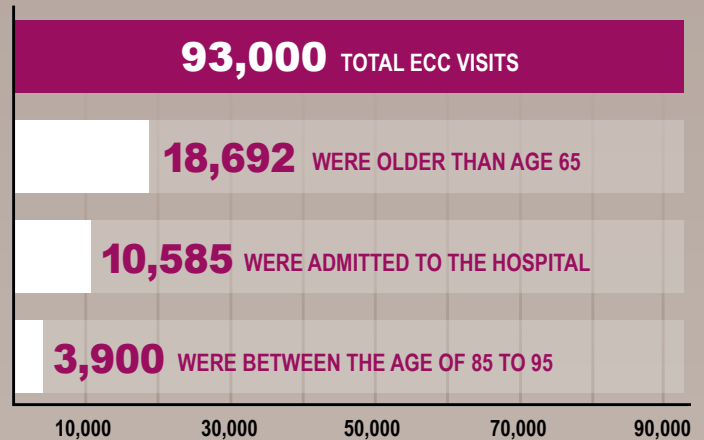
For more information, contact Dr. Risty Kalivas at 989.583.6301 or RKalivas@chs-mi.com.

The Case for Senior ERs

Sample Statistics from Covenant HealthCare

- In fiscal year 2016, Covenant saw 93,000 patients enter the ER.
- Of those, 18,692 patients were older than age 65.
- Of those, 10,585 (or 57%) were admitted to the hospital.
- Of those, around 3,900 were age 85 to 95 years, with around 500 patients older than 95.

COVENANT SENIOR ER PATIENTS, 2016



Extraordinary care for every generation.

Covenant HealthCare
1447 North Harrison
Saginaw, Michigan 48602

The Covenant Chart is published four times a year. Send submissions to Hannah Schultz
hannahschultz@chs-mi.com
989.583.4049 Tel
989.583.4036 Fax

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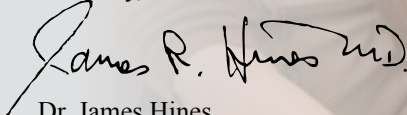
The Sky Is the Limit, continued from page 1

The doctor-patient relationship, however, will remain paramount to the healing process as we continue to provide patient-centric care. At the end of the day, healthcare professionals will still need to address the physical, emotional and spiritual needs of their patients. Communication has become even more crucial as we strive to put our patient needs above our own, and connect with them in the best ways possible.

All of this is embodied in *Our Covenant* and shared vision: *Together, the Medical Staff and Covenant HealthCare are driving extraordinary care and value for our patients and communities.*

As my two years as Chief of Staff come to a close and Dr. Mike Fiore steps into the role, I'd like to say "many thanks" to all of you for your support. I know you will extend the same support for Mike, who brings unique perspectives and experiences to the position.

Sincerely,



Dr. James Hines
Chief of Staff

