THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | MARCH 2015

CONTENTS

2
Clinical Documentation
Drive Accuracy with Fluency Direct™

3
How Advanced Technology Is Changing the Face of Hysterectomy Surgery

4 & 5
Developments in Corneal and Refractive Surgery
Faster Recovery and Better Results

6 & 7
A Strategic Plan Built Upon Core Strategies & Goals
and the Critical Role Physicians Play

8 & 9
Staying on Top of Sepsis

10
CMU College of Medicine Update

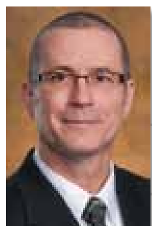
11
Hippocrates 360
Personal Health → Population Health → Personal Health

12 & 13
Making Knees Better with MAKOplasty®

14
The Evolution of Radiation Therapy
at Covenant HealthCare

15
Compact = Joined Together

16
Look for 2015 Physician/NP/PA Engagement Survey in May



Vision for the Future

Dr. James Hines
Covenant HealthCare Chief of Staff

I'm extremely honored to be the new chief of staff at Covenant HealthCare and thank all of you for trusting me with this responsibility.

For those of you who don't know me, I'm a transplanted Hoosier, having been raised in a small rural town in Indiana. I've been married to my wife, Martha, for 40 years and we came to Saginaw in 1987 so I could complete a residency in OB/GYN. She and I, along with our seven sons, consider Saginaw to be our hometown.

As a 16-year-old teenager, I was persuaded to go and listen to a family doctor speak about his work at a rural hospital in the Central African Republic. Some of the pictures were rather graphic with open wounds and fractures, ulcers, malnutrition and parasites. Yet, these medical and surgical conditions created intense excitement in me! He expressed that, "The African nurses are in need of training; who would go and teach them"? So I accepted the challenge! I was determined to become a medical doctor and work and teach in Africa.

The missionary doctor's challenge became a **Personal Vision** of what I was to do with my life. It carried me through the Indiana University School of Medicine, family medicine and OB/GYN residencies, and French language and tropical medicine studies.

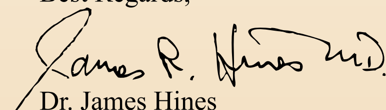
Later, I achieved that vision in 1985 upon arriving in the Central African Republic. There, I started teaching medical classes to the nurses at the Boguila Medical Center, a 100-bed hospital in the middle of nowhere. In return, the nurses taught me about the African culture and its impact on health and healing.

I remember meeting with the hospital administration to discuss strategy, goals, objectives, meeting the budget, and "where we wanted to be in five and 10 years." I felt so inadequate – this had not been a part of my medical school or residency curriculum!

Ultimately, the **Boguila Vision** we developed for that small African hospital was to "provide the best and most up-to-date medical care possible" in the middle of Africa, within our budget. We had an X-ray machine, laboratory, one operating room and all the essential medications. We decided that our medical care should address the whole person – physical, spiritual and emotional.

I am pleased to see how that Vision is similar to the **Shared Vision** that the medical and administrative leadership is developing for Covenant HealthCare – one in which we are committed to work together to drive extraordinary care. We appreciate your support in this effort, and desire that it become an expression of your own motives and desires to provide quality healthcare to our community. The Shared Vision cannot be accomplished without you, and I look forward to working with you to make it a reality.

Best Regards,



Dr. James Hines

Clinical Documentation

Drive Accuracy with Fluency Direct™

GUEST AUTHOR
Dr. Glenn Cipullo, Medical Director of Clinical Utilization

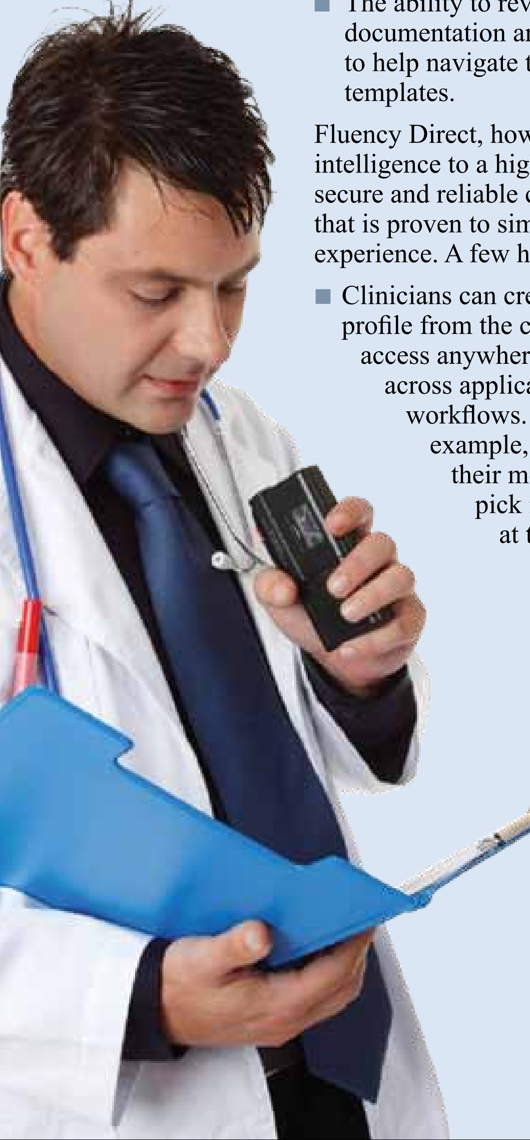
This is the second in a series of articles designed to help improve the efficiency and effectiveness of clinical documentation.

In the last issue of *The Covenant Chart*, we discussed the importance of clinical documentation and accuracy. One way to further improve accuracy, along with flexibility and accessibility, is to use an advanced, real-time, speech-based documentation tool called M*Modal Fluency Direct™. This transcription solution interacts with Epic electronic medical records (EMR), and is starting to be implemented across healthcare systems, including Covenant HealthCare, to replace older technologies like Dragon.

Features & Benefits

As with other speech-enabled tools, Fluency Direct offers:

- Voice-to-text and command-and-control capabilities.
- The ability to dictate directly into the Epic EMR.
- The ability to review and edit clinical documentation and voice commands to help navigate through text and templates.



Fluency Direct, however, takes intelligence to a higher level. It is a secure and reliable cloud-based solution that is proven to simplify the clinician experience. A few highlights include:

- Clinicians can create a personal profile from the cloud that they can access anywhere from any device, across applications, locations and workflows. Clinicians can, for example, dictate a note on their mobile at home and pick it up in Epic later at the office.
- It is fully integrated for front-end recognition.
- Advanced Speech Understanding™ technology provides impressive accuracy, even for users with heavy accents. It also provides contextual understanding to the narrative, capturing the patient's complete clinical story and extracting actionable information to populate Epic EMR. This, in turn, helps ensure the right care decisions are made, and the right documentation for quality, compliance and coding is provided. It also helps drive Meaningful Use, ICD-10 readiness and more.
- Minimal IT support is required. Maintenance and updates occur seamlessly on the cloud, including improvements to language modeling, dictionaries and commands.

Added Value

We would all rather spend more time with patients than on documentation. Fluency Direct can help with that too. Current results in the industry show that it enhances productivity within Epic, adding valuable time to the day that can be better spent with patients or families.

The faster turnaround of quality documentation will improve continuation of care and result in documentation that accurately reflects the severity and complexity of the patient.

Implementation

Fluency Direct is being implemented at Covenant HealthCare with the tentative Go-Live date in March. Initially it will be rolled out to the Emergency Care Center and to physicians who utilize Dragon in their offices. Staff from multiple areas will be trained to help support physicians in the use of Fluency Direct. These groups include eCovenant staff (Inpatient/Ambulatory Documentation), Physician Incomplete Area (HIM) staff, managers and coordinators from CMG, CMU staff and physician liaisons.

> Fluency Direct is relatively easy to implement with minimal time investment.

Fluency Direct is relatively easy to implement with minimal time investment, e.g., 10 minutes to set up a profile and voice training, with an additional hour or less of application training, depending on front-end speech recognition experience. Real-time guidance and closed-loop feedback is available to optimize the experience and assist with activities like ICD-10 transition.

So, if you are looking to take some of the headaches out of documentation, while improving accuracy, productivity and efficiency, Fluency Direct could be the answer for you. Covenant HealthCare wants to provide you with the technology and tools for success. Please look for more news coming your way.

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

How Advanced Technology Is Changing the Face of Hysterectomy Surgery

GUEST AUTHOR

Dr. Deborah Russell, Obstetrician/Gynecologist

Hysterectomy is the second most common surgery among women in the United States, just behind the cesarean section. In fact, about one-third of all U.S. women will have a hysterectomy by age 60.

Thanks to advances in technology, hysterectomies don't always require major abdominal surgery or long recovery times.

When Hysterectomies Are Recommended

Hysterectomies are recommended for two key reasons:

- To treat cancer, including uterine, ovarian, cervical and endometrial.
- To treat a number of benign ailments including fibroids, endometriosis, adenomyosis and pelvic prolapse.

Symptoms may include:

- Problems with periods such as heavy flow – the most common complaint.
- Pain during periods or during sex.
- General pelvic pain, which may include back pain.

It's important to note that many patients believe that a hysterectomy always requires removal of the ovaries, but the strict definition is removal of the uterus. That said, some diagnoses may also require removal of the cervix and ovaries.

Also, age is not a key factor in determining if a hysterectomy should be done. The defining element is if the patient is 100% sure she is done having children, and of course, if cancer is the diagnosis.

Surgical Options

Hysterectomies are often performed via traditional abdominal surgery or minimally invasive surgery. Minimally invasive options include laparoscopic hysterectomy in addition to *da Vinci*® Multi-Port surgery or increasingly, the *da Vinci* single site robotic surgical system – both of which are offered at Covenant HealthCare as important surgical options to treat non-cancerous conditions.

- ***Traditional abdominal surgery*** requires a large incision, similar to that of a C-section. The incision is sutured in the traditional fashion and leaves a correspondingly large scar. Because the surgery is traumatic to the body, it requires a longer hospital stay of two to three nights, and a long recovery time of six to eight weeks.
- ***Laparoscopy*** requires a few abdominal incisions to allow insertion of a tiny camera to guide the operation, and long instruments to remove the necessary organs and tissue.
- ***da Vinci Multi-Port surgery*** is similar to laparoscopy, but provides more vision, control, dexterity and precision due to 3D HD viewing, and special wristed instruments that offer far better flexibility than the human wrist. Most robotic hysterectomies are done multi-port.
- ***da Vinci Single-Site surgery*** provides much better cosmetic results and faster recovery times. Only one small incision is made around the belly button, or sometimes directly through the belly button, and surgeons can typically seal the incision point with steri-strips or surgical glue. Consequently, there is minimal to no visible scarring – an important consideration to women concerned about body image.

Furthermore, the body trauma is minimal compared to abdominal surgery, with low blood loss, low rate of complications and much less pain – which in turn requires fewer narcotics. This enables a same-day outpatient procedure and a faster recovery. Patients are typically able to resume normal activity within a few days and return to work within one to two weeks.

Patient Testimonials About *da Vinci*®

"If I'd known then what I know now, I would have done it instantly; I would have never waited.

Four hours after the surgery, I was up and walking around."

What's Best for Your Patient?

Selecting the right hysterectomy procedure depends on the diagnosis and health of your patient, and if they want more children. The *da Vinci* surgery is delivering excellent results and is the number one minimally invasive treatment for women in the U.S., with the single-site procedure growing in popularity.

Referring your patient to a specialist can help them understand the rewards versus risks of each procedure, and make an informed decision – one that is best for their situation and lifestyle.

For more information, contact Dr. Russell at 989.791.9100 or dlrussellmd@gmail.com. Also see this video at https://www.youtube.com/watch?v=Eg4jyyrJPoo&feature=youtube.

Developments in Corneal and Refractive Surgery

Faster Recovery and Better Results

GUEST AUTHOR
Dr. David Krebs, Ophthalmologist, Envision Eye Care

Exciting advances are occurring in the world of ophthalmic surgery that enable patients to see better and recover faster. Two such advances are in the areas of corneal transplantation – whereby surgeons are now able to replace only the diseased part of the cornea versus the entire cornea, and laser-assisted in-situ keratomilieusis (also known as LASIK) which can now be customized to the patient.

Corneal Transplant Surgery

In 1905, the first successful corneal transplant, or penetrating keratoplasty (PKP), was performed (see Figure 1A) to treat a patient suffering from a chemical burn. Since then, not much has changed except for improvements in cutting, suturing and other techniques. The basic approach has remained the same: cut out the bad cornea – all five layers – and sew in a new donor cornea.

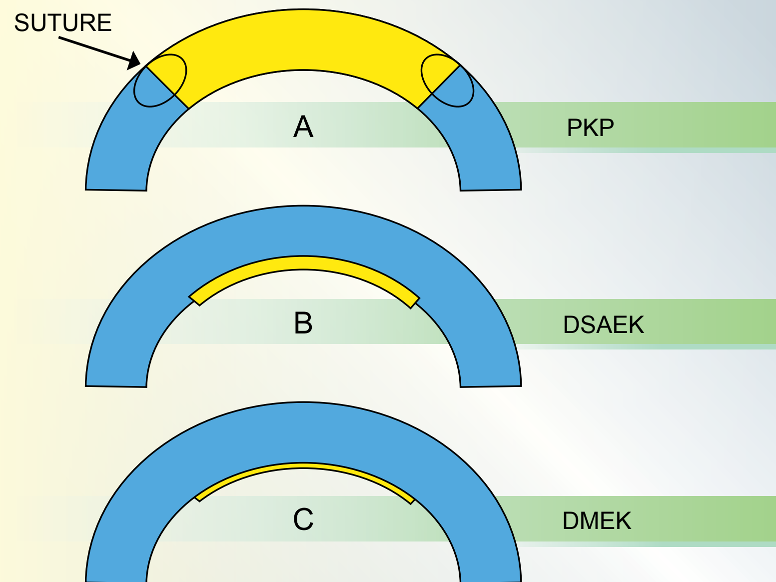
In the past 10 years, however, a revolutionary procedure called Descemet Stripping Automated Endothelial Keratoplasty (DSAEK) is changing the game by allowing surgeons to target and strip out the bad cells on the diseased endothelial layer, and insert new, healthy cells (see Figure 1B). This is done by pre-slicing a donor cornea – just the inner, endothelial layer and Descemet's membrane, where the good cells are located. The graft is folded and pressed onto the back of the cornea via an air bubble (no sutures required), letting the new cells replace the old, damaged ones.

For patients with Fuchs endothelial dystrophy and other diseases, this is huge. In a healthy eye, cells on the inside of the cornea pump fluid out of the cornea so you can see through it. With Fuchs, however, the fluid is retained causing corneal edema, which can eventually lead to light sensitivity, blurred vision and eventual loss of transparency. Correcting this problem early with DSAEK affords the following benefits:

- Patients can avoid the more radical corneal transplant, where they need to wait 6 to 12 months to recover and get glasses.
- Patients enjoy a faster recovery time, getting glasses four to six weeks post-surgery.
- Results are significantly better, retaining natural tissue and avoiding astigmatism and wound healing issues – a side effect of corneal transplants.
- Simultaneous removal of cataracts, a side effect of steroid drops, can be performed at the same time, avoiding another surgery in the near future.

Another procedure still under development is a modification of DSAEK called Descemet membrane endothelial keratoplasty (DMEK). The goal is to further improve recovery time and visual outcomes with an even thinner, targeted graft. In this procedure, the graft contains no corneal stroma – just the Descemet membrane and endothelium, avoiding stromal compatibility issues. It is introduced through a small incision and applied to the existing posterior stroma – again, via an air bubble (see Figure 1C).

FIGURE 1
Corneal Grafting Techniques*



**Yellow areas represent transplanted tissues from a donor.*

Custom LASIK Surgery

Technological advances are also occurring in corneal laser refractive surgery, including LASIK, to make patients less dependent on corrective eyewear. Conventional LASIK, which received FDA approval in 1999, involves reshaping the cornea to improve eyesight. It is a great long-lasting solution for treating lower-order aberrations such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism.

Typically, the surgeon makes a flap in the cornea with a laser, lifts the flap, applies a high-precision excimer laser to sculpt the cornea, then puts the flap back down. It is a fast and relatively painless procedure, with very good results – but until recently, treatment could not be personalized to the patient.

Today, custom LASIK technology allows treatment to be tailored to the individual, addressing both the lower-order aberrations mentioned above, in addition to higher-order aberrations which can cause halos, shadows, glare, poor night vision and reduced contrast sensitivity. Custom LASIK, therefore, not only improves how *much* you can see (e.g. 20/20), but also how *well* you can see.

The difference between conventional and custom LASIK can be compared to buying clothes off the rack versus buying clothes tailored just for you. Custom LASIK is a custom fit, one that measures how light travels through the patient's eye. It creates a 3D map of the eye's unique contours, distortions and visual characteristics (see Figure 2). This data is then transferred back to the laser, allowing the surgeon to guide the laser with pinpoint accuracy and achieve the best results for each patient.

Treatment and recovery time are essentially the same as conventional LASIK, with most people noticing a dramatic improvement immediately after the procedure.

Summary

Good vision is critical to the well-being of every patient. If you have patients who have poor vision due to Fuchs, but were afraid of getting a corneal transplant, they could benefit from the DSAEK or DMEK procedures, which are much less invasive with much better results and a far faster recovery time than a full-thickness corneal transplant.

Furthermore, if you have patients who considered LASIK years ago but were concerned about the potential side effects of glare and halos, they may want to consider custom LASIK instead, since it can be tailored specifically to their needs – minimizing side effects and maximizing outcomes.

These procedures are available in the Great Lakes Bay Region to qualified candidates.

For more information, contact Dr. David Krebs at 989.799.2020 or dkrebs@chartermi.net.

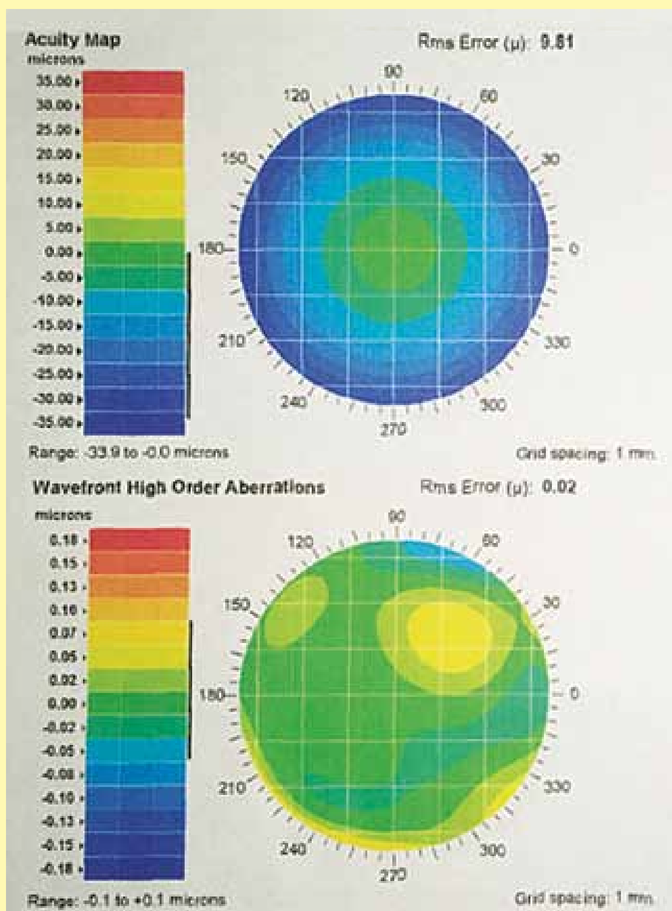


FIGURE 2

LASIK 3D Mapping

PATIENT TESTIMONIAL

"Before LASIK I was always in my contacts, 15+ hours a day. With two small children at home, it was frustrating to get up in the middle of the night and not be able to find my glasses and see – a big problem when needing to look for diapers, pacifiers or medicine!

The decision to get (custom)
LASIK was easy.

I was amazed at being able to read the clock right after! Within a few days, I resumed all of my normal activities and love being able to travel without glasses, contacts, solution and being able to see in the middle of the night."

– Amanda Smith, May 2011

A Strategic Plan Built Upon Core Strategies & Goals
and the Critical Role Physicians Play

Dr. John Kosanovich, Executive Vice President, Physician Enterprise

Last June, the Covenant HealthCare System Board approved six core strategies and related goals that serve as the foundation of the Covenant Strategic Plan for fiscal year 2015 (FY15). In response to physician and provider requests for more information regarding organizational strategy, this article provides a strategic overview and examines the first three core strategies in more detail, including the role physicians serve in forwarding our goals. The June issue will cover the remaining core strategies.

Strategic Overview

As shown in the visual at the right, strategy at Covenant HealthCare begins with our organizational mission. In FY13, the Board changed the **mission** to "Extraordinary care for every generation" to better reflect our organizational purpose and commitment to quality care, and to make it more relatable to staff, physicians and patients. Included with the mission is a strategic vision of what Covenant HealthCare aspires to be, and a core set of **values** that define the culture of our organization, our WeCare Values. The **core strategies** and their **goals** are the foundation of our strategic plan, along with strategic **objectives** (not shown) for each goal that are specifically focused on tasks needed to attain goals.

Our core strategies define our long-range approach to strategy and have approximately a 10-year focus. Strategic goals are usually designed to be achieved in a three- to five-year window. Strategic objectives are tactical and expected to be completed within one or two years.

Every year, the Board initiates planning for the next fiscal year. It reviews, and usually reaffirms, the mission, vision and core strategies. Occasionally, changes are made to the higher level strategy, such as when the Board adopted the new mission in FY13. In FY15, the Board added a new core strategy "Prepare for population health management" to ensure Covenant HealthCare remains nimble in the face of the Affordable Care Act, and is poised for success in the post health reform world.

As part of initiating strategy for the next year, the Board also works with the Covenant Executive Team to define the supportive goals. Working with physician leadership, the Covenant HealthCare Leadership Team then develops the strategic objectives for final Board approval in June.

Below is a summary of the first three FY15 core strategies, and how physicians contribute to success.

STRATEGY I
Pursue Clinical and Patient Excellence

Our ability to deliver clinical and patient excellence is integral to Covenant HealthCare. Many initiatives are underway to accomplish three related goals:

- **Position Covenant as the regional leader in quality.** Covenant HealthCare is constantly working to enhance clinical quality and patient safety. As physicians, this work is at the core of what we do. From leading quality initiatives to furthering knowledge, physicians have a major impact on the quality of care.
- **Improve customer satisfaction.** Ensuring that our patients have an extraordinary experience at Covenant HealthCare rests on the shoulders of everyone who is part of our organization. Physicians and advanced practice providers have a special relationship with patients. Ensuring that our

CORE STRATEGIES, GOALS & OBJECTIVES

MISSION *Extraordinary care for every generation.*

VISION *With a culture built upon an organizational promise of caring and a commitment to service, Covenant HealthCare will be a leading, accessible, and comprehensive health care network serving our communities with extraordinary health care.*

VALUES ***W****orking Together,* ***E****xcellence,* ***C****ustomer Service,* ***A****ccountability,* ***R****espect,* ***E****nthusiasm*

	FY 2015-2025 CORE STRATEGIES	FY 2015-2020 GOALS
I	Pursue clinical and patient excellence	■ Position Covenant as the regional leader in quality ■ Improve customer satisfaction ■ Maintain Covenant as the regional leader in clinical information connectivity
II	Invest in people and culture	■ Develop talent and engagement across the enterprise ■ Implement medical staff development plan ■ Improve physician loyalty and satisfaction
III	Prepare for population health management	■ Pursue population health strategy ■ Experiment bundled payment models ■ Evaluate exchange products with new or existing payor partner ■ Create an integrated medical specialty delivery system
IV	Pursue operational and financial excellence	■ Further enhance throughput and capacity and meet board financial targets ■ Reduce clinical variability
V	Expand scope of services	■ Leverage success and pursue growth in select service lines ■ Formulize service line definitions and structure ■ Increase overall market share in existing service lines
VI	Extend geographic reach	■ Maintain regional network and explore partnerships and formal affiliations ■ Explore expansion in key geographic areas ■ Leverage technology and telemedicine to grow access and outreach

Covenant HealthCare System Board Approved 6/13/14

patients and their families understand their care and can make informed decisions is directly correlated to patient satisfaction, and perhaps more importantly, to better outcomes.

- **Maintain Covenant as the regional leader in clinical information connectivity.** It is largely due to the hard work of our physicians that Covenant HealthCare is the only "Stage Six" hospital in the region for Electronic Medical Record (EMR) adoption. This is the second highest level of EMR adoption identified by the Healthcare Information and Management Systems Society (HIMSS). Clearly, Covenant HealthCare is well ahead of the curve in adoption of EMR technology. This is directly related to how well our physicians embrace and adapt to new information technologies.

STRATEGY II

Invest in People and Culture

Investing in people and creating a culture in which we are proud to work are essential to creating a world-class team, and to sustaining success. Key goals include:

- **Develop talent and engagement across the enterprise.** From developing our own skills to participating in medical education, we all have a big role in maintaining the talent pool at Covenant HealthCare. Through strong teamwork and collegial relationships with residents, nurses and other members of the care team, we encourage learning and make sure the best and the brightest are retained.
- **Implement medical staff development plan.** Excellence attracts excellence. As we recruit physicians to our region, relationships and perception are vitally important. Demonstrating a culture of respect, collegiality, innovation and emphasis on patient care and education can influence decisions to join and stay.
- **Improve physician loyalty and satisfaction.** It's a primary responsibility of Covenant HealthCare leadership to listen and learn from physicians, and to maintain a partnership where physicians feel respected and valued. To this end, Covenant HealthCare needs physicians and advanced practice providers to give their feedback on surveys, in meetings and in personal dialogue so that we can better address issues and concerns. Some of those issues are fairly simple; others are more complex. However, getting the issues on the table and working together to solve them helps ensure that our patients continue to get extraordinary care.

STRATEGY III

Prepare for Population Health Management

The concept of population health represents a mind shift for the health industry overall – hospitals, physicians and consumers. Dr. Williams provides a great overview in his article on page 11. As mentioned, addressing population health was recently added as a core strategy, and is still in the early stages of implementation. Key goals include:

- **Pursue population health strategy.** When you look at health reform, a key element is to move away from episodic care in which a patient presents with a condition, a treatment is provided and a fee for service is received. The goal is to move toward new approaches that keep people and the community healthy in the first place. Success requires prevention strategies to minimize episodes and maximize health, resources to better help those in need, and a collaborative, triangular partnership of hospital-patient-physician. Because population health will impact the face of medicine, it is important for everyone to stay aware of developments and leverage best practices as needed.
- **Experiment with bundled payment models.** As health care reform proceeds, various bundled payment models will be explored, and some physicians may be asked to participate.
- **Evaluate exchange products with new or existing payor partner.** While this is more of a hospital activity, some arrangements may be developed with physicians in Covenant HealthCare Partners who are willing to experiment with new insurance models.
- **Create integrated medical specialty delivery system.** Population health is also about putting models in place to treat patients more efficiently and effectively – improving quality while reducing costs. A few examples are shown in the sidebar above.

Please stay tuned for details about Core Strategies IV-VI in the June issue.

For more information, contact Dr. Kosanovich at 989.583.7555 or jkosanovich@chs-mi.com.

Population Health in Action

Population Health includes creating an integrated medical specialty delivery system that improves quality while reducing costs. Examples include:

- Prescribe the Y – Covenant HealthCare is working with physicians and the YMCA to "prescribe" a healthier lifestyle and to offer a financial savings incentive for joining. Many primary care providers are involved, writing prescriptions for patients who could benefit from the facilities and support of the YMCA. New members get a free, 30-day full facility membership, including orientation and health assessment.
- Saginaw Pathways for Better Health – Covenant HealthCare and a network of other providers have collaborated on a project to investigate new models to improve community health. The project identifies patients with high, unnecessary healthcare utilization, or patients at risk for readmission, and addresses the social determinants of health.

  Saginaw is one of three centers in Michigan to pilot this program, which includes a central "hub" that dispatches community health workers to put patients on a pathway to better health. Physicians have a huge impact on this program because they can refer high-needs patients to the hub for special assistance. It is all good for the patient, physician, hospital and community.

For more information or to see if your patients qualify, please contact the Saginaw County Department of Public Health at 989.758.3850.

Staying on Top of Sepsis

GUEST AUTHORS
Patient Safety & Quality Department: Jessica House, RN, Sepsis Coordinator and Tracy Bargeron, RN, Critical Care CNS

"Severe sepsis" and "septic shock" are major healthcare problems, affecting millions of people around the world each year, killing at least one in four. In fact, more people die in one year in North America from severe sepsis than from breast cancer, lung cancer and colon cancer combined.

Unfortunately, sepsis is increasing in incidence. This is likely due to a combination of factors, including increased awareness and tracking of the condition, an aging population, increased longevity of people with chronic diseases, the spread of antibiotic-resistant organisms, and also an upsurge in invasive procedures and broader use of immunosuppressive and chemotherapeutic agents. Complicating and often delaying diagnosis is the fact that initial signs and symptoms of sepsis such as tachycardia, shortness of breath, confusion and lethargy resemble signs and symptoms seen in other conditions such as CHF, COPD, CKD or dementia.

Sepsis PROGRESSION

EARLY INTERVENTION *SAVES LIVES*

Systemic Inflammatory Response Syndrome

Sepsis Mortality 15%

Severe Sepsis Mortality 20%

Septic Shock Mortality 45%

Multiple Organ Dysfunction Syndrome (MODS)

PERCENTAGES BASED ON NATIONAL DATA

Evidence, however, shows that the speed and appropriateness of therapy administered in the initial hours after severe sepsis will positively influence patient outcomes.

The Global Surviving Sepsis Campaign

After a 2002 international survey of physicians' views on sepsis, a consensus committee of 68 international experts representing 30 international organizations convened to collaborate on best practices for sepsis to create a Surviving Sepsis Campaign (SSC). Sponsoring organizations include the American College of Chest Physicians, American College of Emergency Physicians, American Thoracic Society, Infectious Diseases Society of America and the Society of Critical Care Medicine.

The SSC is committed to reducing mortality for patients with severe sepsis and septic shock by 25%. It features early goal-directed therapy bundles that form the core of sepsis improvement efforts. These include:

- **Sepsis Resuscitation – 3-Hour Bundle Elements**
  1. Measure lactate level.
  2. Obtain blood cultures prior to administration of antibiotics.
  3. Administer broad-spectrum antibiotics within three hours of identification of severe sepsis or septic shock.
  4. Administer 30 mL/kg crystalloid for hypotension or lactate greater than or equal to 4 mmol/L.
- **Sepsis Resuscitation – 6-Hour Bundle Elements**
  1. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) greater than or equal to 65 mm Hg.
  2. In the event of persistent hypotension despite volume resuscitation (septic shock) or lactate greater than or equal to 4 mmol/L (36 mg/dL):
     a. Measure central venous pressure (CVP)*
     b. Measure central venous oxygen saturation (ScvO2)*
     c. Re-measure lactate if initial lactate was elevated.

**Targets for quantitative resuscitation included in the guidelines are CVP of 8 mm Hg, ScvO2 of 70%, and normalization of lactate.*

Early Identification and Intervention Saves Lives

Sepsis is a systemic, deleterious host response to infection with the potential of progressing to severe sepsis with organ dysfunction and worse yet, to septic shock – which is severe sepsis plus hypotension that cannot be reversed with fluid resuscitation.

Healthcare organizations are working hard to increase sepsis awareness. Covenant HealthCare, for example, is committed to reducing sepsis mortality with a coordinated hospital-wide approach to promote early recognition, assessment and treatment of sepsis for patients in the Rehabilitation and Transitional Care Units, ECC, Medical/Surgical units, and Progressive and Intensive Care Units. Other steps to improve results include:

- A new administrative policy to achieve time-sensitive interventions for locating and identifying sepsis. This policy directs nurses to order a lactic acid and appropriate cultures once two SIRS Critera (system inflammatory response syndrome) and a suspected or known infection are both identified.
- A dedicated resource (1 FTE) was added to focus exclusively on sepsis.
- House-wide education for nurses and a new workflow created in the electronic medical record (EMR) to raise awareness and promote early detection of new or progressing signs and symptoms of organ failure with immediate reporting of these changes to the physician.
- Development of a physician taskforce to collaborate on best practices and identify opportunities for improvement.
- Formation of a multi-disciplinary Sepsis Steering Committee comprised of physicians, nursing, pharmacy and administration to drive change and overcome organizational barriers.

Since a high percentage of patients come through the emergency room, many hospitals have implemented a "Code Sepsis" in their emergency departments. This is an initiative soon to be added to the ECC at Covenant HealthCare. After identifying a patient with severe sepsis or septic shock, an overhead alert of "Code Sepsis" is called, with prompt response and intervention. Nursing, phlebotomy, the sepsis coordinator, pharmacy, ECC charge nurses, sepsis team members and leadership are alerted via pager for the Code Sepsis and are expected to respond quickly and efficiently. Treatment includes blood cultures prior to antibiotics, timely administration of antibiotics, LA level and fluid resuscitation as needed. A "Code Sepsis" order set is also being created, complete with early goal-directed therapies and suggested antibiotic pathways.

Your Role

As mentioned, sepsis can mimic other illnesses, so it is important to be vigilant in identification and intervention. Identifying patients with infection and providing immediate treatment is essential to their survival. Please refer to the sidebar for additional warning signs to assist with early goal-directed therapy.

Success in the fight to reduce sepsis requires continued commitment and collaboration of the entire healthcare system, with the collective goal of saving lives and improving outcomes for the patients we care for.

For more information, contact Jessica House at 989.583.6604 or jlhouse@chs-mi.com. Also visit www.survivingsepsis.org.

On average,
7 cases of sepsis are identified
at Covenant HealthCare each day*.

**Data from July 2014 – January 2015*

Sepsis 101: Diagnosis Reminder

An article in the 2012 issue of *The Covenant Chart* featured a useful sepsis diagnosis overview, which is reprinted below for your reference.

SEPSIS

Sepsis is a condition that stems from a poorly regulated inflammatory response to infection. It exists if two or more of the following abnormalities are present, along with either a culture-proven or visually identified infection.

- Fever >100.4°F (38.5°C) or < 96.8°F (35°C)
- Heart rate >90 beats/minute
- Respiratory rate >20 breaths/minute or PaCO2 <32 mmHg
- WBC >12,000 cells/mm3, <4,000 cells/mm3, or >10% immature (band) forms

SEVERE SEPSIS

Severe sepsis is sepsis plus one or more of the following signs of hypoperfusion or organ dysfunction:

- Mottled skin
- Slow capillary refill (>3 seconds)
- Acute oliguria (urine output < 0.5 mL/kg/hour for at least 2 hours despite adequate fluid resuscitation)
- Cr >2.0 mg/dl or >2 times baseline; or GFR decreased by 50% baseline
- Mental status changes
- Coagulation abnormalities (INR >1.5 or aPTT >60 s)
- Jaundice
- Lower platelet count <100,000
- Petechiae
- Elevated plasma total bilirubin >2mg/dL
- Ileus (absent bowel sounds)
- Lactic acid >2 mmol/L
- Acute lung injury or acute respiratory distress syndrome (ARDS)
- Cardiac dysfunction (e.g., left ventricular systolic dysfunction)

SEPTIC SHOCK

Septic shock is severe sepsis with one or both of the following conditions:

- Mean arterial pressure (MAP) is <65 mmHg (or <80 mmHg if the patient has baseline hypertension) despite adequate fluid resuscitation
- Maintaining MAP requires the use of vasopressors

CMU College of Medicine Update

GUEST AUTHOR
Terrance E. Lerash, Executive Director
CMU Medical Education Partners

Like every organization in the healthcare industry, CMU Medical Education Partners is moving quickly to improve and respond to change. We tackled several vital issues for the CMU College of Medicine as we wrapped up 2014 and moved into 2015. A few key areas of focus are summarized below.

Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) continues to evolve as it reviews nearly 9,000 residency programs across the country. The Clinical Learning Environment Review (CLER) is a new program the ACGME uses to assess the learning environment of sponsoring institutions and their participating sites.

We had our first CLER visit in November. ACGME officials visited and observed our residents in their clinical and hospital environments. The CLER visit provides the opportunity for ACGME to observe and monitor the clinical learning environment for patient safety, clinical quality, healthcare disparities, transitions of care, levels of supervision, duty hours and fatigue management, and professionalism.

This was a non-punitive visit because the ACGME is establishing national benchmarks, and the report generated from the visit will help us refine our methods. Subsequent CLER visits will occur every 18 to 24 months.

We are also conducting our own periodic reviews of our active residency programs, and we continue to work with physicians, staff and officials at Covenant HealthCare and St. Mary's of Michigan to ensure we are delivering quality healthcare.

Clinics and Physicians

We entered 2015 continuing to recruit for family medicine and internal medicine physicians and pediatricians. We contracted for inpatient service coverage for Internal Medicine (IM) residents at St. Mary's, and Family Medicine at Covenant HealthCare. Dr. Ronald Bradley, our interim medical discipline chair, is leading our recruiting efforts, and we should be nearly fully staffed – in regards to our clinical faculty – by the end of the fiscal year.

Dr. Harriet Squier and Dr. Shraddha Patel joined our Family Medicine team late in 2014, and we named Dr. Bernard Noveloso interim program director for Family Medicine. Dr. Tiffany Kim is a recent addition to our Obstetrics & Gynecology program.

Construction and Renovation

The lobby renovation of our Houghton Avenue CMU Health Clinic was completed in February, and the new space not only gives us a more up-to-date look, it improves patient flow and security. Next on our list for the Houghton Clinic is to update exam rooms. After some departments move to the new CMU College of Medicine educational building in June, we will renovate the Houghton office areas.

Construction remains on track for the 46,000-square-foot educational building set to open in May, in time for the first group of third-year CMU College of Medicine students. The building will have a large simulation center, advanced technology classrooms, a library and more. We expect to have a community event for physicians later this year in the new building.

The College of Medicine and Saginaw

The CMU College of Medicine attracted 4,600 applicants for its 104-member third class, which will arrive in August. The 64 members of the original class are excited about their third-year curriculum and eager to experience Saginaw and other sites for training.

We entered 2015 in the final stages of settling the third-year students' community clerkships, and we secured a $297,000 telemedicine grant from the United States Department of Agriculture. The video conference equipment will play a key role in the Comprehensive Community Clerkship (CCC) program for third-year students.

The CCC program places students with physician mentors for six months in rural and underserved clinics and hospitals in Michigan for a first-hand view of medical care and patient-doctor relationships as they present cases and participate in simulations.

In January, three candidates for the dean of the CMU College of Medicine were interviewed and in February, Dr. George Kikano was named to the position. He has an extensive background as a family medicine physician, educator and leader. Dr. Kikano will start part-time on April 1 and commence full-time on July 1. Also in February, the Liaison Committee on Medical Education (LCME) visited CMU and Saginaw, and we should learn about the LCME accreditation decision by July.

For more information, contact Jim Knight, director of Marketing and Communications, CMU College of Medicine, at 989.774.2696 or knigh2je@cmich.edu. For the press release about Dr. Kikano, please see http://media.cmich.edu/news/cmu-appoints-dean-of-college-of-medicine.

Hippocrates 360

Personal Health → Population Health → Personal Health

GUEST AUTHOR
Dr. Michael Williams, Hospitalist & Physician Champion, Covenant HealthCare & Covenant HealthCare Partners

It's safe to say we've entered a brand new world. Technological advances never dreamed of decades ago are now reality. Our population is aging, bringing the concomitant ailments of senescence to our offices in ever greater numbers. Immigration and world travel allow foreign diseases to land in our waiting rooms, not just on board exams. Instant access to news and information allows our patients and their families to obtain real-time curbside consults with Dr. Google. In other words, as Dorothy said in the Wizard of Oz, "Toto, I've a feeling we're not in Kansas anymore!"

Harbingers of Change

Of course, none of the aforementioned should be a surprise. Regardless of our starting point, as trailblazing Magellans or head-in-the-sand ostriches, we must admit we've seen the changes coming. In fact, they're not just coming – they've arrived. Even before the passage of the Affordable Care Act, medical practice was evolving. New medications, new therapies and new approaches to healthcare filled our journals. Those who are old enough, or willing enough, to remember the last century (ouch!, right?) perhaps recall the struggle to define, firmly grasp and begin to treat new diseases like HIV/AIDS in the 1980s.

Part of the change we see is encompassed in the concept of "population health," which can be defined as, "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." We have always known that the patient on the exam table is our charge, and has come to us for relief of suffering. It is not such a great leap to realize that our community is made up of the individuals we treat; therefore, we can conceptualize health of the group – our population – as well. Additionally, it is not such a great leap to realize that if we can improve the health of the group overall, the health of the individuals we treat will by necessity also improve. This is "Hippocrates 360" – in the sense that serving the individual and the population returns even greater gains to the individual. Also, just as Hippocrates was among the most outstanding and pivotal figures in medicine, so will population health drive dramatic change for the better.

Accomplishing 360

The rubber meets the road in how to accomplish this aim. We've all had the feeling that if our patients would just be more compliant, health maintenance would be so much easier! It is this type of population that Geisinger Health System faced when approaching this very challenge in 2008. According to the Commonwealth Fund, "Geisinger Health System is a physician-led, not-for-profit, integrated delivery system headquartered in Danville, Pennsylvania. It serves an area with approximately 2.6 million people living in 43 counties of northeastern and central Pennsylvania. In general, this population is older, poorer, sicker, more rural and less transient than the national median. Geisinger's market share is about 30% overall (including both primary and secondary markets) and its annual revenue is more than $2 billion."

The folowing standout quote in their report was particularly eye-catching, dispelling some of the fear of change. "Building an Innovation Infrastructure: Geisinger's leaders believe that the organization can simultaneously improve quality, satisfaction and efficiency only by redesigning and re-engineering how care is delivered, and **not by trying to make people work harder the traditional way."**

Continued on page 13

If we can improve the health of the group overall, the health of the individuals we treat will by necessity also improve.

Making Knees Better with MAKOplasty®

GUEST AUTHOR
Dr. James R. Weir, Fellow American Academy of Orthopaedic Surgeons

The American Academy of Orthopaedic Surgeons calls osteoarthritis (OA) the most common form of arthritis and a leading cause of disability worldwide. The MAKOplasty® surgery, a robotic-assisted partial knee resurfacing procedure, introduces for the first time a surgical solution for halting the degeneration of OA of the knee. Equally important, it now allows adults suffering from early to mid-stage OA to relieve the pain without waiting for total knee replacement surgery. MAKOplasty also allows patients to recover faster and get out of the hospital sooner, while remaining a candidate for total knee replacement in the future, if necessary.

The Procedure

In "Knee 101," the knee is composed of three compartments: medial, patello-femoral and lateral. Usually, OA begins with cartilage damage to the medial compartment, which leads to a subtle angular deformity in the leg. The angularity perpetuates more cartilage damage until a greater angular deformity occurs and the downhill slide of the knee progresses. In time, due to the angularity and cartilage loss, the OA progresses into the other compartments, and a total knee arthroplasty is required to salvage the knee.

Partial knee replacements have been an option, but historically have a high rate of failure due to their inconsistency in correcting the angular deformity – thus allowing the progression of OA described above. In addition, the initial surgery could make future total knee replacement surgeries more difficult due to bone removal and ligament damage.

Consequently, physicians would often steer away from partial knee replacements for patients suffering from early to mid-stage OA, recommending other treatments instead, such as lifestyle changes to reduce joint stress, pain medications, braces and physical therapy.

With MAKOplasty, however, partial knee replacement is now an attractive treatment option for correcting angular deformity. It is performed through a four- to six-inch incision over the knee with small incisions on the femur and tibia. Tactile, intelligent robotic arm technology and real-time 3D visualization of the knee, combined with pre-surgical CT scan data, allows surgeons to resurface only the compartment of the knee that has lost its cartilage – and to do so with great accuracy, precision and consistency. It stops the progression of OA, leading to a highly functional knee with kinematics much closer to a God-given knee than can be obtained with a total knee replacement.

This level of control also enables the surgeon to preserve the patient's healthy bone and tissue, retaining enough structure to facilitate a future total knee replacement, if necessary.

Results and Recovery Time

The MAKOplasty procedure has been gaining traction over the past five years. It requires special training by the physician and surgical team, and is now available at Covenant HealthCare, the only hospital in the region to offer this treatment option. *(See patient testimonial in sidebar at right.)*

With the MAKOplasty, patients experience less scarring and blood loss, and a more rapid recovery. While the amount of time spent in surgery is about the same as a total knee replacement, the length of stay in the hospital is one to two days versus three to four. Patients are allowed to walk shortly after surgery, drive a car within a few weeks and return to normal activities soon thereafter.

Coverage and Candidates

As a knee arthroplasty procedure, MAKOplasty is typically covered by Medicare and other health insurers. For patients to be a candidate and get the greatest benefit, they should exhibit early to mid-stage OA (mild to moderate angular deformity) in just one compartment of the knee, a BMI of less than 32, and not respond well to other therapies. These patients typically demonstrate a great deal of knee pain and stiffness when standing after sitting, or significant pain during activity – on the inner knee, under the knee cap or on the outer knee.

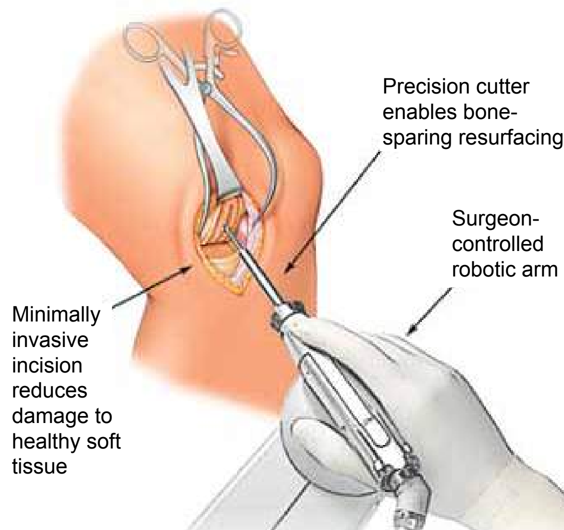
Interestingly, a secondary benefit is the growing interest among patients in weight reduction to obtain the BMI of less than 32 to become a candidate.

MAKOplasty is an important option for relieving pain and restoring range of motion at an earlier stage of the disease, rather than waiting for the OA to advance. It enables patients to take back their life and do the things they enjoy with family and friends.

For more information, contact Dr. Weir at 989.754.7200.

MAKOplasty® Partial Knee Resurfacing

MAKOplasty® Partial Knee Resurfacing offers new treatment options for those living with painful early to mid-stage osteoarthritis of the knee, affecting only one or two components of the knee, and who prefer a less invasive surgery and more rapid recovery than total knee arthroplasty.



PATIENT TESTIMONIAL

MAKOplasty – *The Right Decision*

Ray Pratt, age 70, is an avid hunter and never one to sit for long. He started having issues with his knees, though, and it was getting to the point where he could not get out of the chair without help. So, two years ago, he received a total knee replacement at Covenant HealthCare for his left knee. Once again, he was able to return to the great outdoors, but last fall, his right knee started giving him similar problems.

According to Ray, "I went back to Dr. Weir, my orthopedic surgeon in Saginaw, who told me that the left side of my right knee was basically bone to bone, which was why I was in so much pain. He didn't think I needed a total knee replacement though, and told me about the MAKOplasty option for a partial knee replacement. I don't like to be laid up, and the recovery time was supposed to be faster, so I asked him to sign me up."

Ray went into surgery two days before Thanksgiving. "Recovery was instant," Ray said. "On Day 1 after the surgery, they asked me if I wanted a pain pill and I said nope, I didn't need it. I didn't need it on Day 2 either. I walked to the bathroom with assistance from the nurse, and down the hallway with a walker, and it still didn't hurt. The doctor asked me to try walking without the walker, and still no pain – so he told me to go home, use the cane and start physical therapy. I was home on Thanksgiving Day."

At the start of his physical therapy sessions, the physical therapist was surprised at how much bend Ray already had in his knee – about 90 degrees. "She told me I was doing fantastic," Ray said. "Within a few weeks I was driving and hunting again, and loading wood in the stove all by myself. The recovery is a lot faster and less painful than the total knee replacement, and while my knee gets a little stiff after sitting, it's improving every day. I'm happy with my knee – and so is my wife!"

Hippocrates 360 *continued from page 11*

Six Attributes of the Ideal System

Part of the focus of redesigning and re-engineering took into account six attributes of a conceptually ideal health-care system:

1. Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health record systems.
2. Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.
3. Providers (including nurses and other members of the care team) both within and across settings have accountability to one another, review one another's work and collaborate to reliably deliver high-quality, high-value care.
4. Patients have easy access to appropriate care and information, including after hours; there are multiple points of entry to the system; and providers are culturally competent and responsive to patients' needs.
5. There is clear accountability for the total care of the patient.
6. The system is continuously innovating and learning in order to improve the quality, value and patients' experiences of healthcare delivery.

While those attributes are indeed idealized, by redesigning, we can afford to think big and distill lofty ideas into practical actions and implementation. We can also appreciate that in five of the six attributes (#3 is the exception), the word "patient" appears prominently, so our focus on individuals is well placed. We can do a 360 – or a Hippocrates 360 if you will – whereby we treat our patients individually, improve the population as a whole and thereby help our patients even more.

Standing on the Shoulders of Others

Better yet, we do not need to reinvent the wheel. Covenant HealthCare and other organizations can leverage the concepts of those, like Geisinger, who have gone before us. We can keep the best, discard what doesn't fit, add innovative twists, and build our own better mousetrap right here in the Saginaw Valley.

It can be done. And the reality of healthcare is that it **will** be done, whether we get in front of the curve or are dragged along kicking and screaming. The former is visionary and proactive; the latter certainly more painful.

Future issues of *The Covenant Chart* will discuss in more detail the concepts and actions required to accomplish this lofty, humanitarian and very necessary evolution in the practice of medicine.

For more information, contact Dr. Williams at 989.583.4220 or mdwilliams@chs-mi.com.

The Evolution of Radiation Therapy at Covenant HealthCare

GUEST AUTHOR

Paul G. Kocheril, Medical Director, Covenant Radiation Center

Radiation therapy at Covenant HealthCare started in February 2001 with the formation of the Saginaw Radiation Oncology Center (SROC). This was a three-way joint venture between Covenant HealthCare, MidMichigan Health and Bay Medical Center (now McLaren Bay Region). At its inception, SROC was a state-of-the-art facility with a Varian 21 EX linear accelerator, with its 120-leaf Millennium collimator, and the Brainlab M3 addition for stereotactic brain treatment. However, over time, the winds of technologic change have moved this facility from the leading edge of technology. The addition of imaging technology used by the linear accelerator – such as cone beam CT – enhanced our facility, but it was evident that a more substantial investment in technology would be needed to provide our patients with the best treatment options.

In November 2014, Covenant HealthCare purchased the SROC from the other partner health systems. With the purchase, SROC was renamed Covenant Radiation Center (CRC) and will function as an integral part of the Covenant Cancer Care Center. At the heart of the purchase was Covenant HealthCare's desire to have a competitive, leading edge Radiation Center. It is currently scheduled to be upgraded and reequipped with a new linear accelerator (The Elekta Versa HD™), in addition to a host of new imaging technologies with the goal of providing better, safer and even more accurate radiation treatment.

In general, radiation therapy is part of the overall treatment plan in 50-60% of cancer patients. It makes up one of the four pillars which hold up the base of oncologic treatment; the other three are surgery, chemotherapy and immunotherapy. Technologic changes over the past several decades have focused on improving visualization with advances in imaging technology and improving the precision of delivering external beam radiation treatment with automated treatment methods. The primary goal of treatment is to target the visible tumor and microscopic extension of disease, while avoiding dose to nearby normal tissues and critical organs. The Versa HD will help achieve those goals with better results than ever before.

The Versa HD is a linear accelerator with three photon energies and multiple electron energies. It has a 160-leaf collimator for smoother shaping of radiation fields. It also has the capability of treating at three to four times the dose rate of our previous machine. The previous IMRT (intensity modulated radiation therapy) static field treatments would be replaced by VMAT (volumetric modulated arc therapy), thereby reducing the overall treatment time for large complex fields from 20 minutes down to five to six minutes. The difference between IMRT and VMAT is that IMRT is typically treated with an arrangement of five to nine fields at various locations around the patient.

VMAT allows for treatment to occur dynamically utilizing continuous arcs of varying radiation intensity around the patient. Imaging technologies such as C-RAD would continuously monitor patient positioning and allow adjustments for breathing. Both C-RAD and automated breathing control (ABC) would allow for adapting to the respiratory cycle for treatment to minimize dose to critical structures such as the heart. The new cone beam imaging technology would be significantly faster, provide a wider field of view and clearer imaging of the patient's tumor and normal anatomy.

As the precision of radiation treatment has been improving, there has been a natural tendency to do more stereotactic radiosurgery (SRS) or stereotactic ablative radiation (SABR). These techniques have surgical precision but use radiation instead of a scalpel to eradicate tumors. Generally done in about one to five treatments, SRS and SABR deliver higher than normal doses of radiation at very precise locations within the patient to effectively ablate the tumor.

With a combination of new imaging technology and gating technology, the Versa HD is able to perform radiosurgery type procedures with greater precision and speed. While a comparative device, such as the CyberKnife®, can take up to an hour for doing a SABR treatment, the Versa HD can essentially do a similar treatment in 15 minutes. The improved cone beam CT imaging also will not require the placement of fiducial markers (the placement of gold seed markers which can be seen on biplane x-ray imaging). Ultimately, this will improve our ability to offer SABR to a wider group of the set of patients who may benefit from this type of intense treatment.

The evolution of radiation treatment at Covenant HealthCare is more than just changing the name from SROC to the Covenant Radiation Center (CRC). The CRC will bring in new equipment with expanded capabilities that allow for more effective treatment that is faster, safer and more precise. The facility is scheduled to close for construction the end of March and will reopen July 2015. During this time, the existing linear accelerator will be removed and replaced. The Center will be upgraded with an array of technologic upgrades to allow for tracking of breathing and movement such as the C-RAD system. In addition, the record and verify system will change to Mosaic.

While the facility is closed for the upgrade and remodeling, the Radiation Oncology Practice office at Covenant HealthCare will temporarily relocate to the fifth floor at Mackinaw. Consultation and follow-up appointments will be scheduled at the temporary office. The Covenant Radiation Oncology practice will continue to offer radiation treatment at the surrounding radiation centers while construction is underway.

All these changes will lead to the Covenant Cancer Care Center having a new, leading-edge radiation center to complement its ability to offer state-of-the art, compassionate cancer care to the region.

For more information, contact Dr. Kocheril at pkocheril@chs-mi.com

Compact = Joined Together

Dr. Michael Schultz, Vice President of Medical Affairs

Recently, the topic of physician leadership was explored in the MSMS publication, *Michigan Medicine*. Eight physician leaders in Michigan contributed to a central theme that patients must be put at the forefront. This was clear in regards to managing a practice, hiring healthcare staff, designing cost reduction strategies, advocating for legislative healthcare reform and more.

At the Medical Executive Committee (MEC) Retreat in February, the physician leaders of Covenant HealthCare's Medical Staff, together with its Executive Team and Board of Directors, ratified a Shared Vision and began working on a Compact to achieve that Vision together. Patient centeredness was clearly a driving force, providing common ground upon which the future of healthcare in Saginaw is being built.

Ratified Shared Vision: Together, the Medical Staff and Covenant HealthCare are driving extraordinary care and value for our patients and communities.

To help inspire strategic thinking and alignment, the MEC meeting featured two speakers:

- **Nate Kaufman,** managing director of Kaufman Strategic Advisors, LLC, was the keynote speaker. His emphasis on physician leadership to create the value proposition for future success was compelling. His examples of how physician leaders have taken the driver's seat in many areas of the country to effect very positive changes in patient care while enhancing physician satisfaction were motivational.
- **Jack Silversin,** DMD, DrPH, and president of Amicus, Inc., held a working session to help the group understand aspects of change required for achieving a shared Vision, and the elements of a Compact – which is the means to achieving the Shared Vision. It establishes rules of engagement and reciprocal expectations between, for example, the medical staff and hospital administration.

One important point is the need to assume positive intent. People who enter the healthcare field (e.g., physicians, nurses, administrators) are intent on doing good and great things, not on delivering suboptimal healthcare. It will be vital to remember this going forward.

Compact development is the next stage after creating a shared Vision. One definition of Compact is "joined together," which in turn implies collaboration and a mutual focus. A Compact establishes rules of engagement and reciprocal expectations for success.

As a group, we made great progress at the MEC Retreat, agreeing on many points, including:

- Our relationship needs to evolve to be successful with our Vision, and we're in this together.
- The Vision and Compact are mutual, and so is our focus on doing what's best for the patients, and on making quality easier and our work simpler.
- We must work in partnership – the physicians and the hospital with the support of the Board – to provide extraordinary care.
- The MEC will be focused on engaging the Medical Staff in the process of working on the Vision and Compact over the next year.
- It is critical to start now; we must not kick the can down the road.

On a personal note, at the MEC Retreat I observed a certain enthusiasm and optimism about the future that I have not seen for a long, long time in the healthcare arena – it is most refreshing. This work positions us well for success in the face of uncertainty coming our way. Your reactions and inputs to the Shared Vison and Compact are needed, so please talk with your MEC representative or contact me directly.

For more information, contact Dr. Schultz at 989.583.4103 or mschultz@chs-mi.com.

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Look for 2015 Physician/NP/PA Engagement Survey in May

As part of our Core Strategy #2 to invest in people and culture (see article on pages 6 and 7), Covenant HealthCare implements a Physician/Nurse Practitioner/Physician Assistant Engagement Survey. Please look for the 2015 survey in May. Your feedback will help us continue to enhance the work environment and will be used to assess what we are doing right and what needs to improve.

What To Expect

The survey is simple, short and user-friendly. It asks questions that assess:

- ***Employed physician/NP/PA*** level of loyalty and emotional commitment to the organization as well as perceptions of hospital culture, support, teamwork, compensation, recognition and professional development.
- ***Independent physician/NP/PA*** level of business loyalty and strategic allegiance, as well as perceptions of hospital support, clinical care and patient access.

How To Begin

You will be receiving email notifications and other reminders, and will have one month to complete the survey. Please look for the survey link via Epic email and remember that the more feedback we receive, the better we can create the most attractive environment.

Last year, response rates for physicians increased from 45% in the prior survey to 56%; it was also the first year we included advanced practice providers. This year, let's drive it even higher. It is time well spent.

After the survey is closed, results and actions will be reviewed and shared via *The Covenant Chart*, physician meetings and other avenues.