THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | MARCH 2014

CONTENTS

Giving Patients Access to Personal Health Records

Convenience + Confidence

Dr. Sara Rivette, Covenant HealthCare Chief of Staff

A growing number of hospitals with advanced electronic medical record (EMR) systems such as Epic – including Covenant HealthCare – have started to offer patients electronic access to their personal health records. Using a secure password, patients can access information such as alerts, labs, diagnosis, medication lists, treatment programs, after visit summaries (AVS) and patient discharge instructions. Certain information, such as the provider's notes, is not available.

In Epic, this capability is called MyChart. Key patient benefits are available from the comfort of their home and include the flexibility to:

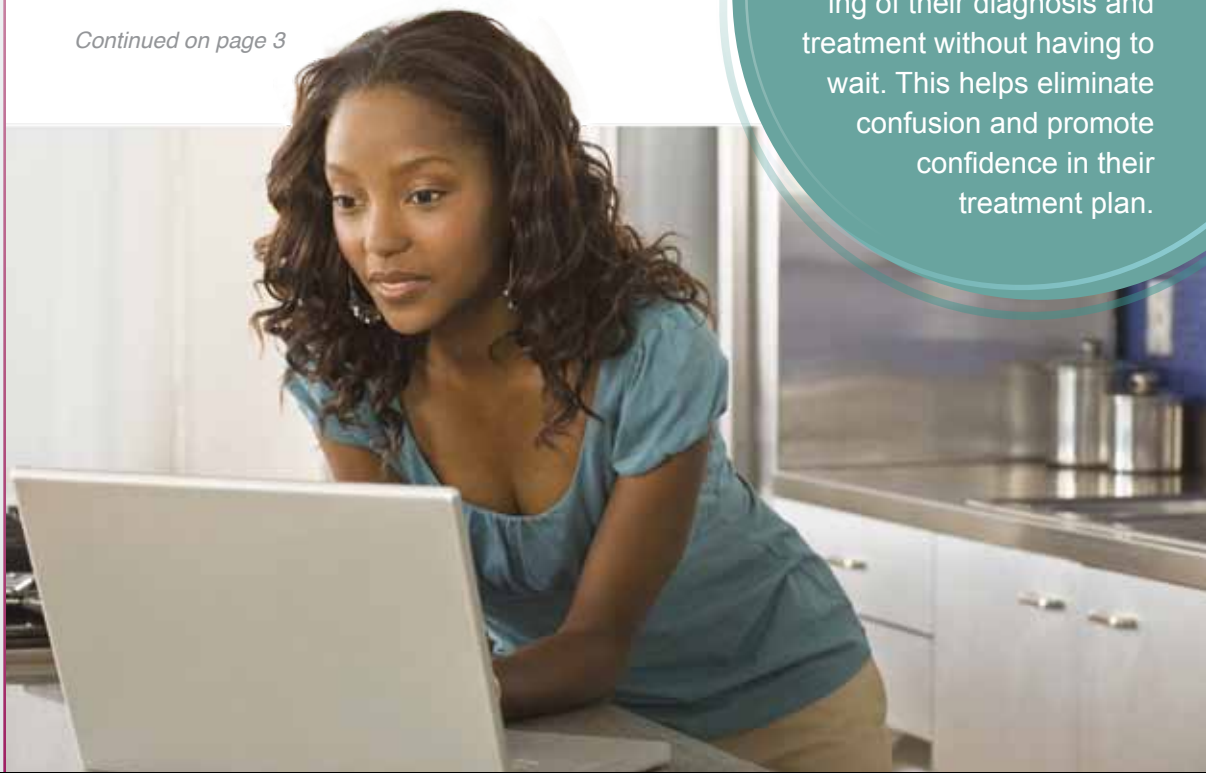
- Get 24-hour access to individual medical records.
- Request or cancel an appointment.
- Request a medication renewal.
- Ask non-urgent medical questions.

The value of this is significant:

- **For patients**, it is a convenient way to reaffirm their understanding of their diagnosis and treatment without having to wait. This helps eliminate confusion and promotes confidence in their treatment plan.

Continued on page 3

Patient access to medical records is a convenient way to reaffirm their understanding of their diagnosis and treatment without having to wait. This helps eliminate confusion and promote confidence in their treatment plan.



Breast Feeding and Our Role in Revitalizing the Global Economy

GUEST AUTHOR
Dr. Audrey Stryker, Obstetrician-Gynecologist, Women's OB-GYN, Saginaw

This article is a follow-up to the December 2013 breast feeding article about the Baby Friendly Hospital Initiative, Best Fed Beginnings and the benefits of breast feeding.

As health care providers, we have a unique responsibility to seize opportunities to improve the health and well-being of our community. Interestingly, breast feeding has become a health factor that has the potential to decrease morbidity and mortality for the patients of all physicians – from cardiologists and ophthalmologists to general surgeons and family practitioners. It can also drive economic savings in our communities, state and country.

However, due to cultural trends and lack of full support from the medical community, women across the United States are choosing NOT to breast feed despite the fact that with few exceptions, breast feeding is far superior to formula for mothers and their babies – plus, it's free!

With formula feeding as the norm in certain communities (including ours), the very concept of breast feeding is the obstacle, as many people just don't understand the benefits. Plus, there is a learning curve that challenges even the best-supported mother-baby dyad. How do we overcome these obstacles? First, by understanding the benefits of breast feeding and second, by taking up the rallying cry to promote it.

Breast feeding can help create a healthy Michigan without the current morbidities related to obesity, hypertension, diabetes and depression. Healthier children have improved educational performance, which in turn is linked to higher socio-economic status and quality of life.

Understanding the Benefits

From the economic perspective:

- Women who choose to breast feed their babies for the first year of life will save their families $1,200-$1,500 in formula costs alone (this does not include savings in bottles, nipples, etc.).
- Researchers estimate that if 80% of U.S. families exclusively breast feed for six months, $3.6-$13 billion per year would be saved nationwide in pediatric health care costs due to the health benefits of breast feeding.

From the health perspective, scientific evidence ***overwhelmingly*** indicates that breast feeding is the single most powerful and documented preventive modality for diminishing infant mortality in developed countries. In our December article entitled "Breast Feeding: An Affordable Healthcare Act," we reviewed those benefits along with the role that Covenant HealthCare and other hospitals are playing in the Best Fed Beginnings collaborative, which is aimed at helping communities transition to breast feeding.

Women who breast feed:

- Will see in their **children** lower rates of diarrhea, otitis media, lower respiratory tract infections, Type 1 and Type 2 diabetes, childhood leukemia, necrotizing enterocolitis and sudden infant death syndrome.
- Will see in **themselves** a lower risk of Type 2 diabetes, breast and ovarian cancer. Mounting evidence suggests a reduction in depression as well as cardiovascular morbidities.

The Bottom Line: Breast feeding can help create a healthy Michigan without the current morbidities related to obesity, hypertension, diabetes and depression. Healthier children have improved educational performance, which in turn is linked to higher socio-economic status and quality of life.

Taking Up the Rallying Cry

Together, health care providers should take up the rallying cry of breast feeding to promote good health from Day 1 of life. In this way, we can create a new generation of enlightened women who pioneer breastfeeding in their neighborhoods – women who are equipped with all the support they need to succeed, including reinforcement from the entire medical community.

"While breastfeeding may not seem the right choice for every parent, it is the best choice for every baby."

– Amy Spangler
Author

So if you have a pregnant patient, or hear that a member of the patient's family is "expecting," be an advocate and take the opportunity to discuss the benefits of breastfeeding. Breast cancer surgeons, for example, can encourage it as a way to decrease breast cancer in the next generation. Primary care physicians and cardiologists can recommend it as a way to reduce hypertension, diabetes and coronary artery disease in at-risk families.

For some physicians, breast feeding may seem like a topic out of their comfort zone, but once you make it a part of the process of delivering quality care, the discussions become second nature and the benefits can become exponential.

Also consider:

- Sharing articles, handouts and statistics about breast feeding with patients, including how it prevents problems in your area of expertise.
- Educating your staff about Best Fed Beginnings and the benefits of breastfeeding, so they (and you) can pass the message along to their own families and friends too, not just to patients.
- Inviting a staff member with breast feeding experience to provide patient support.

Once women see that we collectively endorse breastfeeding – just as we endorse healthy diets, exercise and smoking cessation, and once they better understand the benefits to them and their newborns, we can accelerate the paradigm shift. We can create a "new norm" in which patients make breast feeding the preferred health choice.

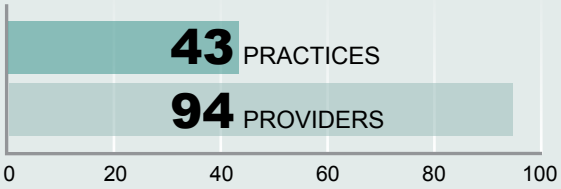
For more information, contact Dr. Stryker at dreestrykr@aol.com or 989.792.3100.

Giving Patients Access continued from page 1

- **For hospitals**, it helps ensure that patients follow their treatment plan, plus it avoids some repetition in explaining diagnosis and treatment.
- **For families** with children, the elderly and infirm, it provides them (assuming they have a signed HIPAA consent) with an avenue to validate what has been communicated and to assist with the proper treatment.

Aside from streamlining patient care, electronic access can improve patient safety 24-7. For example, if lab results are provided at night or on a weekend, such as confirmation of a urinary tract infection, the physician can update the med list immediately with an email automatically going to the patient, instructing them to log into their MyChart. In this way, treatment can start right away.

PRACTICES AND PROVIDERS ON MYCHART*



How does a patient get access?

- **In the hospital.** When patients are discharged from Covenant HealthCare, the MyChart activation code is printed on the patient's AVS. They are provided with sign-up instructions, but can also ask the hospital staff for help during their stay. Once the patient has created an account, it is easy to navigate the website.
- **In the physician's office.** The front desk staff or nurse asks the patient to sign a consent form. The staff then prints an activation code for the patient that includes instructions on how to register and download a mobile app. The patient will need the activation code and some personal information (such as birthday and social security number) to open the account, ensuring that the right information goes to the right patient.
- **Note:** If a patient receives an activation code as an in-patient and their provider is not live on Epic, the patient will not have the ability to interact with their specific provider via MyChart (e.g. messaging and refills).

The phenomenon of giving patients access to their personal medical records is catching on everywhere. If you don't have this capability, you might want to explore it. If you do have it, remember to promote it. It's a win-win for physicians and patients alike.

Sara L Rivette MD

Dr. Sara Rivette, Chief of Staff

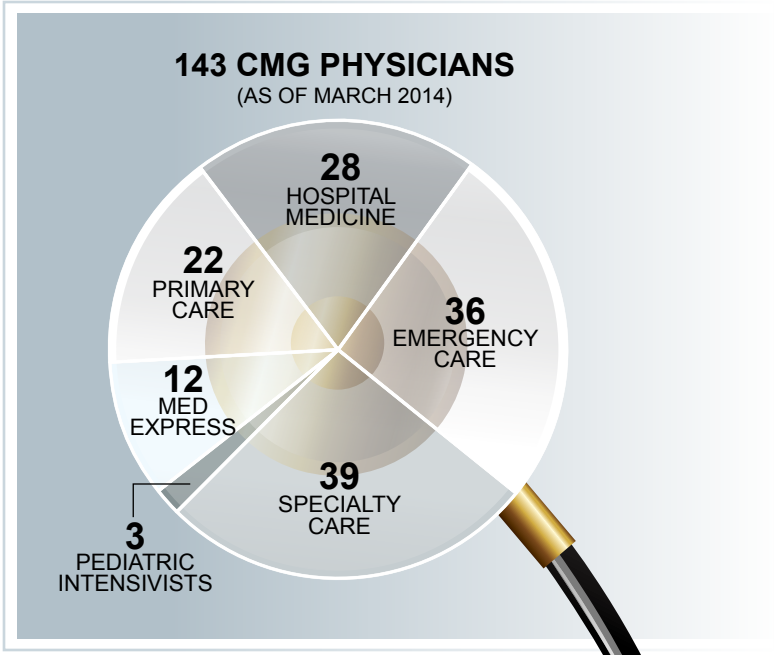
**AS OF JANUARY 2014*

Progress and Growth
Covenant Medical Group Update

Dr. John Kosanovich, CEO, Covenant Medical Group

Prior to 2012, Covenant employed many physicians, but there was no organizational structure to unite the group of doctors. To provide that structure, the Covenant Medical Group (CMG) was officially introduced in August 2012. Today, CMG is a physician-led and professionally managed group of physicians focused on maximizing the quality of care they deliver to the community.

The Network Operating Committee is the group's governing body, consisting of 12 elected physician members. Three supporting committees help with governance: Operations and Finance, Culture and Physician Resources and Quality and Professional Affairs. Each committee is made up of at least six physician members. This structure allows for a degree of physician autonomy with respect to governance.



Over the last few years, CMG has experienced exceptional growth. There are now close to 145 physicians representing both primary and specialty care (see the figures). Recruitment priority continues to be in primary care.

That said, there are multiple specialty needs for the region and quite often the only way to attract candidates is through direct employment. Recently CMG has been successful with signing critical care/pulmonary physicians and is rebuilding the gastroenterology service. At the same time, there are many independent physicians who desire employment for a number of reasons – not the least of which is the changing environment of healthcare. The CMG has been addressing those opportunities when they arise.

Going forward, CMG will continue to focus on addressing the needs of the community and physicians. It values the contributions of independent-loyal physicians as well as employed doctors and is driving a mutually productive alignment between the two groups. Both provide an important element of diversity in thought and skills.

Working together, we will create an even stronger health care sector, one that improves the overall health of our communities.

For more information, contact Dr. Kosanovich at 989.583.6047 or jkosanovich@chs-mi.com.

CMU College of Medicine Gears Up

Dr. Michael Schultz, Vice President of Medical Affairs

The pool of physicians serving the Saginaw region is growing. In 2011, a partnership was formed between Covenant HealthCare, St. Mary's of Michigan and Central Michigan University (CMU) to take medical education to new levels of excellence across the Great Lakes Bay Region – bringing new talent to our community.

The resulting CMU College of Medicine (CMED) was founded with a primary mission to provide access to high-quality healthcare in underserved areas in Michigan, including Saginaw County and Isabella County. CMED is teaming up with quality physicians/instructors in these areas, and attracting physicians to fill important gaps in the fields of psychiatry, pediatrics and more.

The inaugural CMED class was enrolled in August 2013. The overwhelming majority are from Michigan with a personal desire to remain in the state, providing an important pipeline of local talent. For Saginaw, this means an even stronger hub of health care that will improve access to medical services, draw more professionals to the region and help revitalize the economy.

Below are a few fast facts:

- The inaugural class of 64 students had 58 students from the state of Michigan, of which 11 have undergraduate degrees from CMU, 14 from the University of Michigan and 7 from Michigan State. The class is 56% female. The average GPA is 3.65 and MCAT score is 28.
- The second and subsequent classes will number 104. Of the 96 students who accepted (as of year-end 2013), 83 are from Michigan. The class roster will be finalized after May 15, when more demographics will be known.
- Students will be on the CMU campus for most of their first and second years. The curriculum includes time spent with physicians in clinics, mostly in Mt. Pleasant. Many of the third- and fourth-year students will be in Saginaw.
- The new CMED education building is under construction on the Covenant HealthCare campus, and students will work alongside physicians at Covenant HealthCare and St. Mary's.
- CMED offers residency programs to which students may apply, which would extend their time and commitment to Saginaw.

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

– Ali Hachem, a first-year student from Detroit and vice president of the Medical Student Council, was asked about his inaugural class and expectations for the second class.

"The quality of students you find here at CMED is exceptional. I feel fortunate to be a part of a class that is not only academically outstanding but is also filled with **unique, genuine and caring individual leaders**. There is no doubt that CMED will continue to admit the most qualified applicants that fit its values and mission."

Loss of Limb
Amputee Continuum of Care

GUEST AUTHORS
Dr. Babu Nahata, Director, Inpatient Rehabilitation Center and contributor Lynn Geyer, Physical Therapist

Each year, more than 130,000 individuals in the United States undergo the amputation of a limb due to illness or accident. It takes an amputee about two years to reach maximum potential use of a prosthetic limb, partly because they have many challenges that affect quality of mobility and life at both the pre-amputation and post-amputation stage. It is highly important that everyone involved with these patients provide a continuum of care.

Standards of Care

Many standards of care recommend that an amputee be in contact with at least one professional from their healthcare team every three months for the first 18 months post-amputation, followed by every six months for the amputee to reach full potential.

The mobility potential of amputees varies based on the reason for the amputation, type of amputation, comorbidities and environment. All amputees should reach a minimal level of household mobility and should not be expected to be wheelchair bound. With proper standards of care applied, amputees should at least reach *limited* community mobility, with many expected to reach *unlimited* community level mobility and return to vocational and community activities.

Although the cause of the amputation will drive the surgical procedure (e.g., tying off muscles, cutting dying tissue), there should be a standard of care tailored to each person that includes the following treatment objectives by stage:

- **Preoperative Stage:** Preparation for amputation involves patient education about the process and potential prognosis; preoperative rehabilitation with a physical therapist (PT) and/or cardiac rehabilitation for increased strength and range of motion (ROM) of all extremities and core; and education about future mobility and realistic goals.
- **Acute Stage:** Post-amputation includes patient education about residual limb healing and shaping; acute/hospital PT and occupational therapy (OT) for basic mobility; activities of daily living training with durable medical equipment (DME) provided as needed; referral to physiatry (inpatient rehabilitation consult or outpatient consult if patient is able to return home post-surgery); discharge setting planned and completed; referral to prosthetist for immediate post-operative prosthesis and temporary limbs.
- **Sub-Acute to Chronic Stage:** When the residual limb is healed enough, activities include weight-bearing exercises through PT; creation of a prosthetic wear and use schedule; prosthetist follow-ups on limb needs; and management of nutrition and comorbidities.
- **Community Integration or Stable Stage:** When a definitive prosthetic limb is provided, activities include a return to recreational activities; community programming to break through plateau periods away from therapy (e.g., the Covenant HealthCare Step Up! Amputee Program or other local programming for mobility); peer support and education; physiatry follow-ups with therapies being re-consulted as appropriate; and vocational rehabilitation as relevant.

Appropriate Referrals

Amputees are at high risk for being lost in the system without appropriate referrals as check points throughout their care. All physicians and healthcare professionals play a role in an amputee's two-year recovery period, but if those key referrals are not in place, the patient may never reach their full potential or mobility beyond a wheelchair or walker. This limits quality of life while increasing healthcare expenses with continued health problems.

Appropriate referrals pre-amputation and post-amputation are as follows:

- **Preoperative PT evaluation and treatment:** Begin home exercise program and education about amputee care; increase strength and flexibility; decrease risk of contractures.
- **Physiatry:** Allows for one physician to be in contact with the patient from postoperative status forward. A patient will discharge from the operating surgeon's care eventually and a primary care physician may not be able to make informed prosthetic or rehabilitation recommendations. A physiatrist can bridge these gaps of care for overall patient monitoring.
- **Postoperative Rehabilitation:** If the patient qualifies for inpatient rehabilitation or skilled nursing facility rehabilitation, this is the ideal choice. Another option is temporary home care followed by more intense outpatient care once the patient becomes more mobile. Outpatient referrals should include PT, with OT considered for treatment of upper extremity strength and daily living activities (ADL's).

- **Prosthetics Services:** If possible, a referral should be made prior to surgery for fitting, manufacturing and follow-up of the prosthesis. Otherwise, the referral should be made immediately post-amputation (see sidebar).
- **Psychology:** Whether the injury is traumatic or chronic, a life-changing event has occurred involving significant emotional upheaval. This, combined with the tendency for patients to reach plateaus in mobility and care, leave them depressed and stressed. It is important for them to have counseling to overcome their fears and challenges.
- **Case management/social work services:** Amputees often need extra support and community resources for day-to day-needs, transportation to/from appointments and more. Without this support, many amputees are not able to start the needed services, missing critical appointments.
- **Dietetic Services:** The intent is to help patients avoid weight gain due to reduced mobility, and promote healing with a nourishing diet. It involves education for caloric intake, sodium reduction, food recommendations and discussion about the overall medical condition.
- **Wound Center:** Services include residual limb healing, debridement and care of intact limbs.
- **Pain Center:** Provides support to patients who have uncontrolled phantom or intact limb pain affecting all mobility and ADL's that cannot be addressed through typical medication and PT.

Goals

The ultimate goal in treating amputees is to help them achieve functional independence, maximize mobility and improve their quality of life. The standards of care at each phase of amputation, combined with the appropriate referrals and follow-throughs, provide the most effective level of patient and family education, understanding and progress.

Prosthetic Limbs and K Levels

In 1995, the Medicare Functional Classification Level, otherwise known as K Levels, was introduced. This five-level coding system categorizes the mobility potential and abilities of a person with a **lower limb** amputation, as well as what is reimbursable for a prosthetic prescription. Each level allows for a more complex prosthetic limb.

K Levels are measured by use of the Amputee Mobility Predictor testing tool using various sitting and standing balance, mobility, somatosensory and vestibular objectives. K Levels include scores for a person with and without use of a prosthetic limb (see chart below). The use of any assistive device is also considered, with increased points achieved for a less restrictive device.

K Levels can be used to judge progress throughout an episode of care, and to update a prosthetic limb to include more technology and improved components.

For more information, contact Dr. Nahata at 989.971.0580 or bnahata@chs-mi.com.

K LEVEL	MOBILITY LEVEL	PROSTHETIC PRESCRIPTION AVAILABLE
0	Does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance quality of life or mobility.	Not eligible for prosthesis
1	Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence. Household ambulator.	**Ankle-Foot Prosthesis:** External heel, SACH* feet or single axis ankle/feet **Knee Prosthesis:** Single-axis, constant friction knee
2	Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs or uneven surfaces. Limited community ambulator.	**Ankle-Foot Prosthesis:** Flexible-heel feet or multi-axial ankle/feet **Knee Prosthesis:** Polycentric, constant friction knee
3	Has the ability or potential for ambulation with variable cadence. A community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic use beyond simple locomotion.	**Ankle-Foot Prosthesis:** Flex foot and flex-walk systems, energy storing feet, multi-axial ankle/feet, or dynamic response feet **Knee Prosthesis:** Fluid and pneumatic control knees
4	Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of the child, active adult or athlete.	**Ankle-Foot Prosthesis:** Any ankle-foot system appropriate **Knee Prosthesis:** Any ankle-knee system appropriate

**Solid Ankle Cushion Heel*

Bipolar Disorder versus Major Depression Disorder
The Consequences of Misdiagnosis

GUEST AUTHOR
Dr. Ali Ibrahim, Psychiatrist, Hospital Psychiatry, PLLC

Because they are so common, mood disorders are often treated in the primary care setting. The most typical disorders are major depression disorder (MDD) – also known as unipolar depression; bipolar I and II disorder; and mood disorder due to a medical condition.

Due to the overlap of symptomatology, it is difficult to make a distinction between bipolar disorder and MDD. Nevertheless, it is important for clinicians to develop the right diagnosis since the treatment modalities often differ and misdiagnosing a bipolar disorder can have many adverse clinical consequences. That said, the distinction can be challenging, even for astute, seasoned psychiatrists.

It is easier to diagnose bipolar I disorder since it presents with a manic episode or a mixed episode that is not caused by a medical condition or substance abuse. But bipolar II disorder often presents with depressive symptoms, which can make the diagnosis more challenging. The clinician should be suspicious for bipolar disorder versus MDD if any of the following are observed:

- The patient is not responding to different treatment modalities for MDD.
- There is a strong family history of bipolar disorder.
- There is a strong personal or family history of substance abuse.
- If usage of an antidepressant creates an unstable mood or severe anxiety.
- If the patient or family recollects an episode of hypomania or impulsivity.

Also note that ADHD is more often comorbid with bipolar disorder than unipolar depression.

Consequences of Misdiagnosis

There are clinical consequences for treating bipolar disorder with antidepressant agents alone. Among them is the possibility of a rapid-cycling type of bipolar where a person has four or more episodes within a year – including a manic episode with all its negative consequences (e.g., dangerous impulsivity, erratic behavior, homicidal and suicidal behaviors). This makes the disease more challenging to treat overall and worsens the prognosis.

Therefore, before initiating treatment for MDD, clinicians must make a concerted effort to rule out a bipolar diagnosis.

Tools and Treatment

Tools to aid in the diagnosis of bipolar disorder include the Mood Disorders Questionnaire (available online). In addition, a thorough clinical interview is indispensable. Collaborative family input should be sought when an episode of hypomania is suspected, since most patients do not have good recollections of their prior hypomanic episodes.

An example of hypomania would be episodes in which the patient is observed to be exceptionally cheerful, requires very little sleep or talks more rapidly than usual. Hypomania can interfere to a degree with daily functioning while mania can significantly impair daily life. Behaviors are more extreme and out of control, such as laughing loudly at a serious event, and may include delusions and hallucinations.

The good news is that each disorder, when diagnosed properly, can be treated in ways that enable patients to lead a healthy and productive life.

Treatments, in general, are as follows:

- **The treatment of MDD** involves psychotherapy, especially cognitive-behavioral therapy in conjunction with antidepressants or electroconvulsive therapy (ECT).
- **The treatments for bipolar I mania** are anti-manic agents such as lithium, valproic acid, carbamazepine and a number of atypical anti-psychotics (second generation), such as Saphris or Latuda.
- **The treatment for bipolar II depression** can be quite difficult. But there is some evidence that quetiapine or lamotrigine can be helpful for this condition.

After a preliminary exam and discussions, a referral to a psychiatrist can help fine-tune the diagnosis and treatment.

For more information, contact Dr. Ibrahim at 989.996.0566 or aliibrahim.md@gmail.com.

Bipolar I

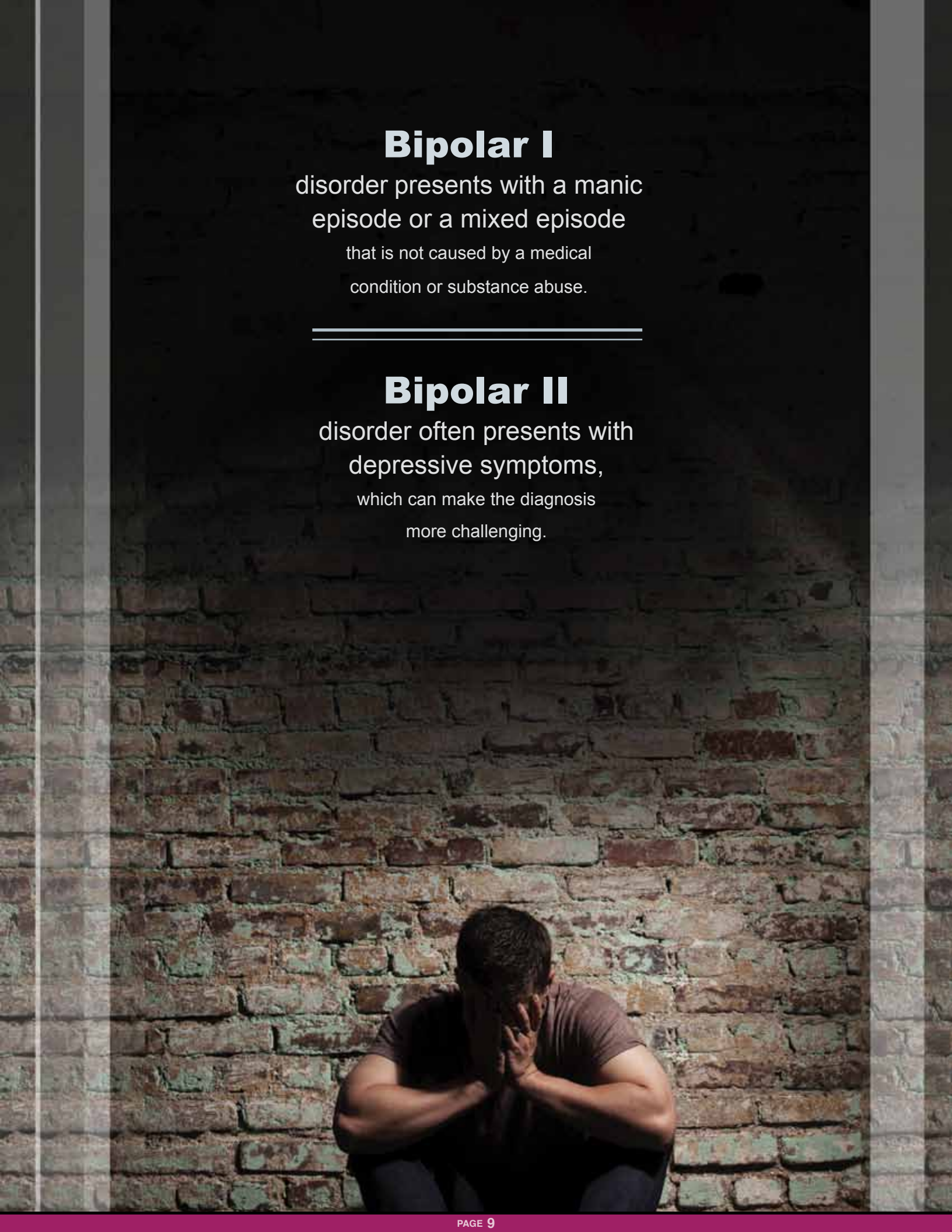
disorder presents with a manic episode or a mixed episode

that is not caused by a medical condition or substance abuse.

Bipolar II

disorder often presents with depressive symptoms,

which can make the diagnosis more challenging.



2013 Provider Engagement Survey
Snapshot of Results

Dr. Michael Schultz, Vice President of Medical Affairs

Good news! The 2013 Provider Engagement Survey Team received a 56.2% response rate with 301 responses, or about a 10% improvement over last year. We truly appreciate your participation as your feedback helps Covenant HealthCare focus on the things most important to you.

Survey Paths

Participants answered a set of questions based on their professional relationship to Covenant HealthCare. For 2012, we had two key survey paths – one for Covenant HealthCare-employed physicians AND closely affiliated independents, and another for other independents who don't primarily practice at Covenant. For 2013, however, we modified those paths so that all physicians employed by Covenant HealthCare follow a different survey path than the independents (see Table 1).This approach eliminates some confusion on survey questions and will improve future reporting. In addition, we added Advanced Practice Providers (APPs) to the survey, specifically nurse practitioners and physician assistants.

Results

Results were calculated according to the new survey paths. Level of engagement was measured for the Covenant HealthCare-employed providers. Level of alignment was measured for all independents.

- The engagement ranking runs from being highly engaged and loyal to the organization with the desire to go above and beyond, to being disengaged and unhappy with one's role or the organization.
- The alignment ranking runs from being highly aligned strategically and financially to the organization with a strong commitment to admit or refer patients, to being disaffected and unhappy with a low likelihood of admitting patients.

While the survey team is still reviewing the results and action plans, Figures 1-3 provide a sneak preview.

- **Figure 1:** Covenant HealthCare is outperforming the HABC (Healthcare Advisory Board Company) engagement and alignment benchmarks, exceeding the 94th percentile for engagement and the 73rd percentile for alignment.
- **Figure 2:** Due to the change in survey groups, "Covenant-employed" is the only group that we can compare year-over-year results. As shown, Covenant HealthCare continues to move employed providers into the "content" and "engaged" rankings.
- **Figure 3:** This reflects the addition of APPs to the mix, but separates their responses from physicians. The top bar shows the combined results of those two groups. In all groups, the vast majority of respondents rank their experience with Covenant HealthCare as "content and engaged" or "loyal and aligned."

Next Steps

The goal of Covenant HealthCare is to address matters of importance with employed and independent providers, the success of which will be measured by additional movement of employees and independents to the highly engaged and highly aligned rankings.

Detailed results will be shared at the March meetings of the Medical Executive Committee and Active Medical Staff, including improvement opportunities and priorities. They will also be shared among smaller provider groups going forward. Further analysis of all findings, along with feedback on the findings, will lead to specific action plans. Please stay tuned for more information.

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

TABLE 1

SURVEY GROUPS AND PATHS, 2012 VS. 2013

SURVEY GROUPS	2012 SURVEY PATH	NEW 2013 SURVEY PATH
Covenant HealthCare *Measure: Engagement*	Covenant HealthCare-employed physicians AND closely affiliated physicians	• Covenant HealthCare-employed physicians only • Covenant HealthCare-employed APPs
Independents *Measure: Alignment*	Other independent physicians who do not practice primarily at Covenant HealthCare	• All independent physicians and APPs who practice at Covenant HealthCare

FIGURE 1

OUTPERFORMING THE BENCHMARK, COVENANT-EMPLOYED PHYSICIANS VS. INDEPENDENTS*

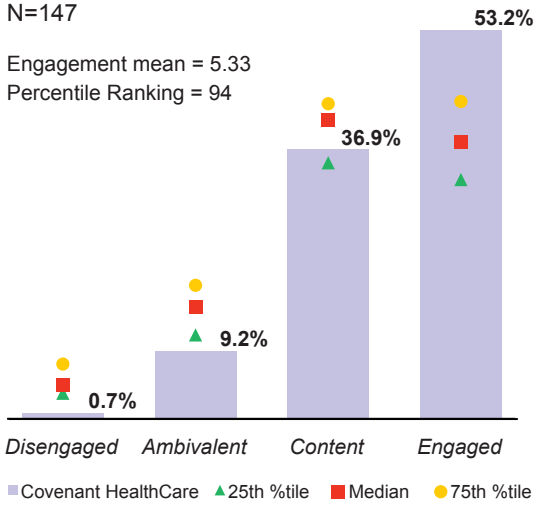
COVENANT EMPLOYED

Overall Engagement Relative to HABC Benchmark

N=147

Engagement mean = 5.33

Percentile Ranking = 94



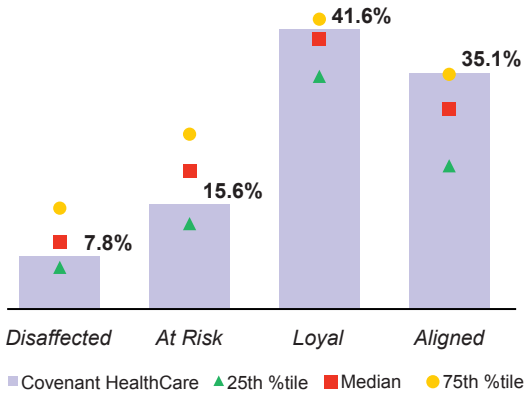
ALIGNED

Overall Alignment Relative to HABC Benchmark

N=154

Alignment mean = 4.98

Percentile Ranking = 73



*The engagement benchmark includes 220 organizations with over 8,000 responses and the alignment benchmark includes 140 organizations with 5,000 responses.

FIGURE 2

INCREASING ENGAGEMENT, COVENANT-EMPLOYED PHYSICIANS

COVENANT EMPLOYED

Overall Engagement Relative to HABC Benchmark

2012 N=85; 2013 Physicians N=118

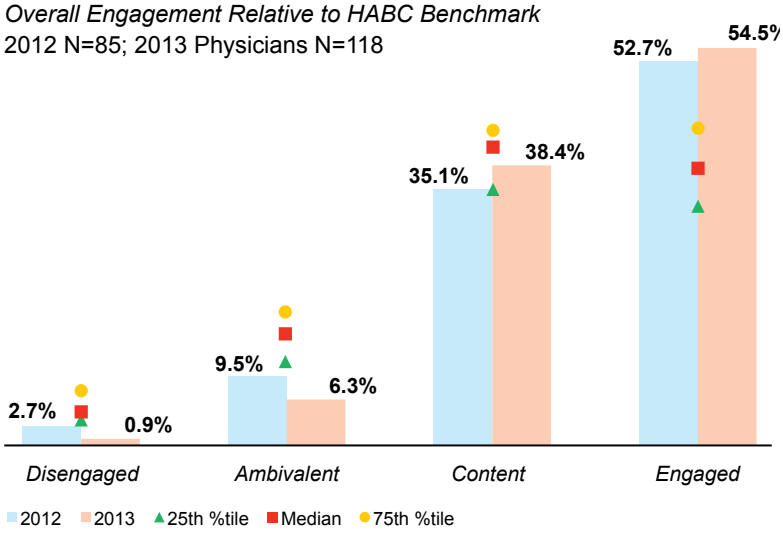
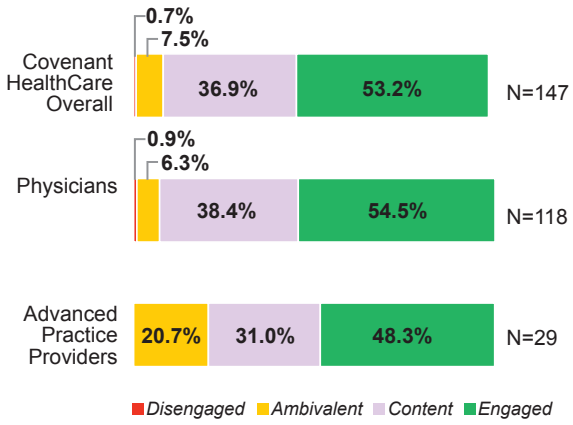


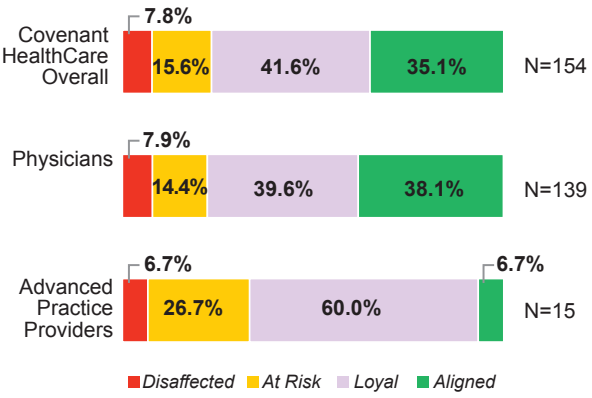
FIGURE 3

PHYSICIANS MORE ENGAGED AND ALIGNED, COVENANT-EMPLOYED GROUPS VS. INDEPENDENTS

COVENANT EMPLOYED



ALIGNED



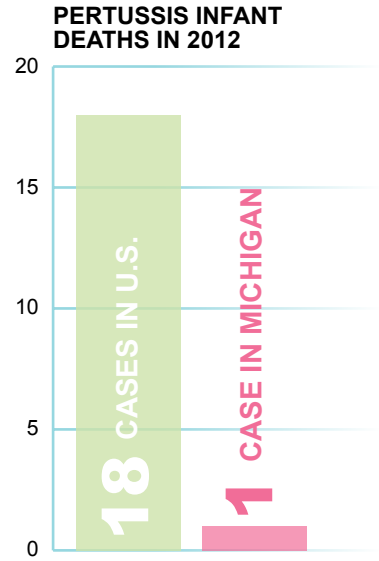
Offering a Cocoon of Protection for Newborns

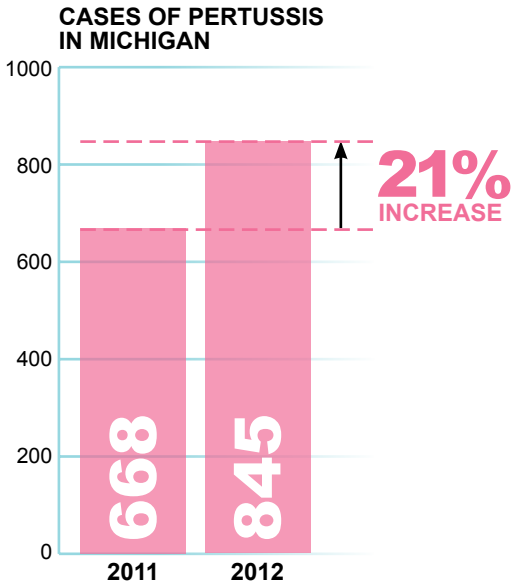
Pertussis Prevention Strategies and Booster Update

GUEST AUTHOR
Dr. Jackie Robinson, Obstetrician/Gynecologist, Valley OB/Gyn Clinic

Pertussis, or whooping cough, has received a lot of press lately – and for good reason. We are seeing a disturbing rise in pertussis cases, which are at epidemic levels in some locations.

Consider this: in 2012, 48,277 cases of pertussis were reported in the United States, the most since 1955. Of those, more than 845 pertussis cases were reported in Michigan, a 21% increase over 2011. The Centers of Disease Control (CDC) received reports of 18 pertussis-related deaths in 2012, with most occurring among infants under 3 months of age – one of whom was in Michigan.





Protecting Infants

As you know, infants are more vulnerable to pertussis, which affects them at greater rates with more significant symptoms. About one-half of infants under 1 year of age who get pertussis will require hospitalization and unfortunately, 1% will die due to complications of the infection.

One important way to protect infants is with the Tdap vaccine. Healthcare providers should make sure they are up-to-date regarding the recommendations for the pertussis vaccine. Relaying this information to patients is vitally important to the effort of keeping our newborns safe.

Tdap Vaccine

Tdap, an inactivated tetanus-diphtheria-pertussis vaccine, was developed in 2006 due to epidemiologic studies that connected the rise in cases to the waning immunity of the adult population. As more and more adults had minor symptoms of pertussis, they unknowingly exposed infants and children to the bacteria. Symptoms in adults can range from prolonged upper respiratory symptoms to the classic whooping cough. The latter is characterized by coughing fits that culminate in an inspiratory whoop. Infants, however, do not have the strength for the forceful coughs that are needed to clear the secretions associated with pertussis and are thus at high risk for apneic episodes.

Cocooning Strategies & Recommendations

There are two basic strategies for creating a "cocoon" of protection for infants:

1. **The first prevention strategy is to prevent the illness in those who come into contact with the infants, including families and caregivers.** The CDC and Advisory Committee on Immunization Practices (ACIP) have issued recommendations regarding pertussis, which are supported by the American Academy of Pediatrics and the America College of Obstetrics

and Gynecology. While a Td (tetanus-diphtheria) booster is recommended every 10 years, it should be replaced at least one time with the Tdap for people over the age of 14. This can be given earlier than the 10-year interval for those who have not had the Tdap vaccine.

2 **The second yet equally important prevention strategy is to encourage soon-to-be-moms to get their Tdap booster, so that important antibodies can be passed along.** For this group, it is recommended that Tdap be given during each pregnancy. Tdap can be safely administered during any trimester, but the ideal time is between 27 and 36 weeks gestation. By giving the vaccine to pregnant women, the passive immunity is enhanced, which equips infants with antibodies to protect them when they are most susceptible. Women who did not previously receive the Tdap should be immunized in the immediate postpartum time period. Tdap is safe to give to breastfeeding moms. Infants should also start the vaccination series at 2 months of age.

We've all seen the consequences of not having the pertussis vaccine. Please see the true story below about the danger of pertussis and the benefits of Tdap.

For more information, contact Dr. Robinson at 989.753.8453 or jrobinson@vobsaginaw.com.

TRUE STORY

How Tdap Helped Fight Pertussis

A third child was born! A beautiful, healthy little boy named "John." When John started sniffling a few weeks later, his Mom and Dad thought he had caught a slight cold from his siblings – after all, it was going around. But when things got worse and he had a hard time catching his breath, they took John to the hospital where he was promptly admitted into the PICU.

According to John's aunt, "He was coughing so hard, he was blue and everyone was a wreck emotionally, worried he was going to die. We were terrified even though we have several nurses in our family. There were many sleepless nights of feeling frightened and helpless."

John was intubated immediately and isolated for the first 36 hours, while being treated with IV fluids and antibiotics. Tests were performed and confirmed pertussis. Once the apneic episodes eased a little, he was extubated so as not to become dependent on the ventilator. He spent a grueling 16 days in the PICU. Once his episodes became fewer with greater lengths of time in between, and he was able to recover from the coughing without help, he was sent home with oxygen to help him overcome lingering spasms of coughing.

Today, John is once again the picture of health. He was lucky, though. His physicians believe that the Tdap booster Mom received during her pregnancy gave him enough antibodies to fight off the infection. Because he was not yet old enough for his own vaccination, however, he was vulnerable to exposure.

After seeing the impact of pertussis on John and its ripple effects, his Mom and Dad are huge advocates for the Tdap and other childhood vaccinations. It's an experience they pray no one else has, and one that a simple booster can prevent.

Preventing Fatal Blood Clots in the Hospitalized Patient

GUEST AUTHOR
Dr. Anu Gollapudi, Hospitalist, Physician Champion for VTE Committee

As healthcare institutions seek to improve quality and reduce costs, they are sharply focused on prevention. One of the most common causes of death in the hospitalized patient is pulmonary embolism (PE) due to deep vein thrombosis (DVT) – also known venous thromboembolism (VTE).

PE: A Leading Killer

Routine autopsies estimate that 10-25% of all hospital deaths involve emboli in the lung, many of which are extensive enough to be considered the cause of death. In addition, some patients who died suddenly at home (after hospitalization) are thought to be the victims of massive, unforeseen PE. While a terminal illness contributed to most of those PE deaths, a significant number involved ordinary patients having just a few co-morbidities – people who should have lived a normal and healthy life.

According to the American College of Physicians:

- An estimated 1 in 100 patients admitted to a hospital dies because of PE.
- About one-half of these at-risk patients could have been saved if effective prophylaxis was used.

Prophylaxis and Best Practices

Covenant HealthCare continues to follow major industry best practices. To help prevent blood clots, a VTE BPA (Best Practice Advisory) has been initiated to fire in the electronic medical record (EMR) for those patients with no VTE prophylaxis ordered.

These pulmonary emboli removed at autopsy look like casts of the deep veins of the leg where they originated.

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The VTE BPA:

- Begins alerting providers six hours after admission for patients who have a documented VTE risk of 2 or greater and no pharmacological is ordered.
- Will not fire for patients who have orders for heparin infusion, warfarin, dabigatran, rivaroxaban or apixaban.
- Includes a "sub-therapeutic" version of BPA which fires if the above criteria are met and they are on those medications, but their therapeutic INR* is less than 1.7.

Note: Once pharmacological or mechanical prophylaxis are ordered in Epic, or the order for "Reason for not Initiating VTE Prophylaxis" is entered, the VTE BPA will no longer fire.

Moving forward, this is what can be expected:

- Unit-based floor monitoring of patients to ensure mechanical devices are fully and properly used.
- Patient education for DVT prevention, including patients on anticoagulants.
- Further adjustment of hospital protocols using best practices.

The good news is that despite PE being a major source of mortality and morbidity, it is also highly preventable via the VTE BPA and other strategies. Physicians and nurses will be kept informed as changes are made.

If you have questions, contact Dr. Gollapudi at 989.583.4220 or agollapudi@chs-mi.com, or contact Jessica House, RN, Patient Safety and Quality, VTE Committee Chair at 989.583.6604 or jlhouse@chs-mi.com.

**International Normalized Ratio*

CG-CAHPS: Are You Ready?

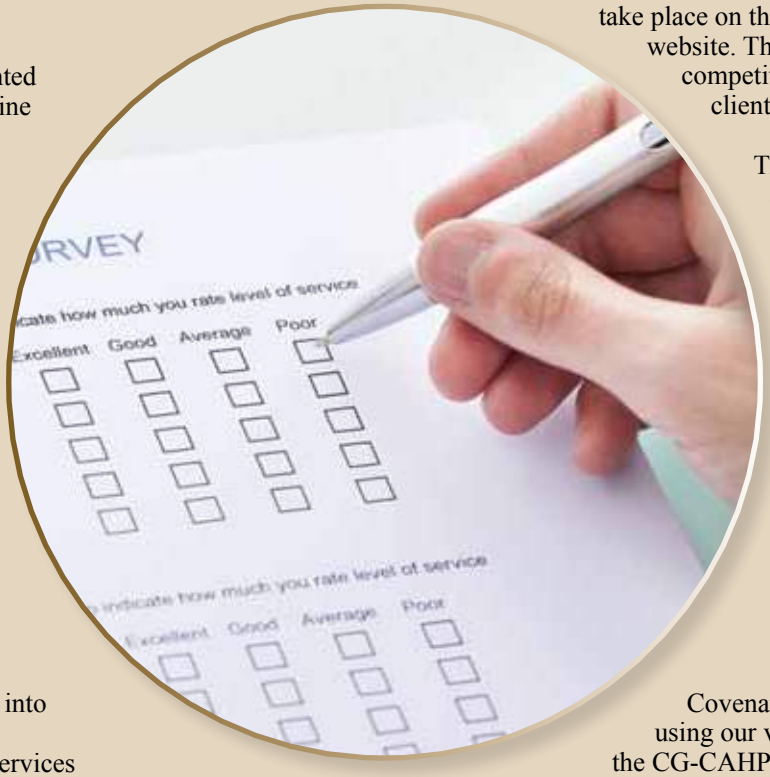
Dr. John Kosanovich, CEO, Covenant Medical Group

As you are no doubt aware, the Centers for Medicare and Medicaid (CMS) have been creating CAHPS (Consumer Assessment of Healthcare Provider and System) surveys for a variety of service lines to increase public accountability and transparency. For an institution to get full reimbursement on costs, the CMS needs to ensure that patients received good quality of care and are satisfied.

CAHPS At-a-Glance

Since 2008, CMS has implemented the following surveys to determine reimbursement:

- **H-CAHPS: Hospital** (went into effect in 2009)
- **HH-CAHPS: Home Health** (went into effect in 2009)
- **In-Center Hemodialysis CAHPS:** (went into effect in 2012)



Meanwhile, the CMS is in various stages of collecting baseline data for the following service lines. After the baselines are set, these service lines will also base reimbursement on survey data:

- **ED-CAHPS:** Emergency Department (expected to go into effect in 2015)
- **AS-CAHPS:** Ambulatory Services (expected to go into effect in 2015)
- **CG-CAHPS:** Clinicians and Groups (expected to go into effect in 2015)
- **Rehabilitation Facilities CAHPS:** (timeframe unknown)
- **Inpatient Pediatrics CAHPS** (timeframe unknown)

Preparing for CG-CAHPS

The CG-CAHPS initiative is of particular importance to clinician and physician groups. Here is what you need to know and do to prepare in advance:

- CMS should begin collecting data for practices participating in Physician Quality Reporting System (PQRS) Group Practices starting in 2014.
- The survey will be conducted by mail followed by a telephone follow-up.
- It is expected there will need to be a minimum of 300-400 returns per medical group, and the survey will be sent to a random sample of Medicare fee-for-service patients who were seen in the last 12 months.
- Mid-level providers will be included based on the definition of 'eligible provider' as anyone who has been assigned their Medicare billing rights to the group's tax ID number.
- Once data is collected, public reporting should take place on the Physician Compare website. These scores will be viewed by competitors, payers and prospective clients.

This survey will have four areas of focus:

1. **Access to Care** Getting appointments, care and information when needed.
2. **Physician Communication** How well the provider communicates with patients.
3. **Office Staff** Helpful, courteous, and respectful office staff.
4. **Global Rating** Patients' global rating of the provider.

Covenant HealthCare is currently using our vendor Press Ganey to send the CG-CAHPS survey for employed physicians in the Covenant Medical Group. It began sending this survey in May 2013. Press Ganey has over 21,000 physicians in their CG-CAHPS database that Covenant HealthCare is being benchmarked against.

Resources

Look for occasional updates to CG-CAHPS progress in *The Chart*. Meanwhile, if you would like to see a sample copy of the full survey or have questions, please contact Alison Henige at 989.583.4261.

For more information, contact Dr. Kosanovich at 989.583.6047 or jkosanovich@chs-mi.com.

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Send submissions to Maryvonne DeSmyter
at the Office of Physician Relations.
mdesmyter@chs-mi.com
989.583.4036 **Fax**
989.583.4040 **Tel**

Countdown to ICD-10
Education Planning Underway

Dr. Michael Sullivan, Chief Medical Quality and Informatics Officer

The October 1, 2014, rollout date for ICD-10* is fast approaching. The Covenant Implementation Plan is being followed to ensure Epic and other software are compliant, staff are educated, and claims can be produced and processed by insurance companies.

Physicians will begin to see an increase in their involvement in the preparedness plan. Covenant HealthCare's clinical decision support (CDS) staff recently received education on ICD-10. They are reviewing the existing physician queries made in ICD-9, and revising those that need changes due to ICD-10 documentation requirements.

In addition, the hospital has selected a vendor to provide training to physicians. AHIMAs' *Clinical Documentation for ICD-10 by Specialty: Principles & Practice*** is a web-based product that will be tailored to physicians based on specialty. The implementation plan will target a spring or summer release of the education modules. Once installed, each physician will be able to access the modules from Covenant HealthCare, or from their office or home. The product consists of focused, two- to three-minute web-based tutorials that will be accessible from within Epic at the point of documentation.

Covenant HealthCare is providing this training free of charge to all staff-privileged physicians and practitioners. The team is currently working with AHIMA to review historical coding information and create curriculum modules for each physician.

Stay tuned for more updates as we finalize education plans.

For more information, contact Dr. Sullivan at 989.583.7351 or msullivan@chs-mi.com.

* International Classification of Diseases Tenth Revision

** American Health Information Management Association: *Clinical Documentation for ICD-10 by Specialty: Principles and Practices*

Principles & Practice is a web-based product that will be tailored to physicians based on specialty. The implementation plan will target a spring or summer release of the education modules.