THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | MARCH 2020

The Guardian Angels of Covenant HealthCare

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

As a member of the medical staff, do you know who grants your privileges? Are you aware of who has the final say with respect to setting the hospital's mission, or for selecting which projects are set in motion and incorporated into the strategic plan?

The answer? The Covenant HealthCare Board of Directors. These individuals are members of the Great Lakes Bay Region who volunteer their valuable time to Covenant HealthCare, including its medical staff, employees and the patients we serve.

These honorable people are all leaders selected to provide fiduciary oversight for everything that happens within the hospital's domain. The Chief Executive Officer of the hospital and the medical staff report directly to the Board. As Chief of Staff, it is my honor to represent the medical staff to the Board at their monthly meetings. I have been incredibly impressed by just how engaged and dedicated they are to the hospital over the course of many years. Their service involves a huge amount of responsibility and time.

While the Board is not comprised of medical experts, they assign responsibilities for monitoring and managing the medical staff and depend on us to be accountable to each other and them. I can promise that they are brilliant at grasping issues at every level. They participate in many committees, from finance and investments to patient safety and quality. When new surgical technologies are introduced into practice, they research the training and expertise required for our medical staff to deliver the extraordinary care that Covenant is known for. As the largest healthcare provider in the region overseeing over 600 physicians, it is also vital that our Board stays abreast of changes in medical practice – from information technology to insurance reimbursement – and they surely do.

Let me cite one example of Board service, namely Larry Sims. Larry is a former Board Chair who dedicated over 20 years to serving on our Board. Prior to the merger of St. Luke's and Saginaw General Hospitals, he also served as chairman of the Saginaw General Hospital Board for many years. Larry retired from the Board at the end of 2019 and we should all give him a grateful note of thanks for his selfless service. Imagine the countless hours he has given to the purpose of asking the most important question over and over again: "Is this activity good for Covenant and the patient's trust in our care?"

Ultimately the Board is responsible for the oversight of patient care. They ensure that the care we give meets or exceeds standards for quality and safety. Those standards, in fact, drive much of what the Board reviews every month, including how patient care can be continuously improved – like our compliance with handwashing.

When compliance rates dip, I feel embarrassed because I don't have an answer to the question "Why don't the physicians cleanse their hands 100% of the time?" It seems logical that we would, but unfortunately not everyone does. So, please help improve our compliance with this and other crucially important steps toward excellence. Let's show everyone that we take quality and safety seriously.

Each of our Board members are truly "guardian angels" for the community and patients seeking care at Covenant. I thank all of them – and Larry – for navigating our hospital into extraordinary waters.

Sincerely,

K Cowling

Kathleen Cowling

CONTENTS


Anesthesia Today: *More Options, Greater Safety, Fewer Side Effects*

Dr. Vasil Mamaladze, Anesthesiology, Saginaw Anesthesia Services and
John Rzyhak, Nurse Anesthetist/Anesthesia Services Manager, Covenant HealthCare

In today's world of patient-centric care, patients are becoming increasingly involved with medical decisions. A growing number are asking questions about anesthesia due to concerns about safety and side effects, and are often more fearful about anesthesia than the surgical procedure itself.

Patients should know that today's medical advances offer more options while minimizing risk. Below are a few facts about anesthesia that can help educate your staff and patients.

Types of Anesthesia

Fact: *Anesthesia doesn't always mean "going to sleep." Of the three types of anesthesia below, only one involves an unconscious state.*

- **General anesthesia** is what many people think of when they hear "anesthesia." This puts the patient to sleep with a complete loss of consciousness. It is typically used for abdominal, chest or brain surgeries. **Sedation anesthesia** falls under general anesthesia with three options: mild (relieves anxiety), moderate (can respond to external stimuli) or deep (can only respond to painful or repeated stimuli).
- **Local anesthesia** involves numbing a specific part of the body to prevent pain.
- **Regional anesthesia** blocks pain in a larger part of the body, such as an arm, leg or everything below the waist.

Anesthesia Safety and Advances

Fact: *All types of anesthesia are considered safe, with technological improvements making complications very rare. For example, in the 1960s-1970s, a death related to anesthesia occurred in one of every 10,000-20,000 patients. Today, death is about one in every 200,000 and continues to decrease.*

Specific areas of progress include:

- Opioid-free anesthesia options to address the opioid crisis. Local/regional anesthesia is used wherever possible along with non-opioid adjunct therapeutics such as NSAID's, gabapentin, ketamine, magnesium sulfate and dexmedetomidine.
- Newer drugs for local/regional anesthesia, such as Exparel®, which allows for a delayed release of the drug. This provides longer duration of anesthesia for the tissues and nerves requiring numbing.
- A newer drug (sugammadex) that can quickly reverse the effects of certain muscle relaxants commonly used during surgery, including paralytics requiring immediate reversal in case of a failed intubation attempt.
- Refinements in ultrasound units used to guide placement of nerve blocks. Better resolution helps differentiate nerve fibers in surrounding tissue, allowing a more targeted injection of local anesthetic.

Anesthesia Trends

Fact: *Anesthesia is trending toward sedation or regional anesthesia when possible. This is primarily due to new drugs and diagnostics and the move away from opioids.*

At most healthcare institutions, for example, transcatheter aortic valve replacement (TAVR) was typically performed under general anesthesia. Ongoing work, however, is validating the use of sedation anesthesia instead – which Covenant now uses for most TAVR procedures. General anesthesia is typically reserved for patients who have certain criteria, such as morbid obesity, respiratory compromise or spine/musculoskeletal problems that prevent them from laying flat for extended periods.

Anesthesia Selection and Side Effects

Fact: *Anesthesia is tailored to the patient and side effects are typically minor.*

When evaluating a patient, the anesthesia team first assesses if the surgical area can be anesthetized and surgery performed without requiring an unconscious state. For total knee or hip replacement surgery, for instance, regional anesthesia is the usual choice unless there are contraindications. This avoids the common side effects of general anesthesia, such as nausea or vomiting, a sore throat if intubated, delirium or confusion, and dry mouth (symptoms that typically disappear within 24 hours).

That said, patients are NOT candidates for regional anesthesia when there are:

- Absolute contraindications, including lack of patient consent, skin infection at the site of needle insertion, or a nerve blockade.
- Relative contraindications, such as coagulopathy, neuropathy, systemic infection, excessive patient anxiety, mental illness and anatomic distortion.

Alleviating Fears

If patients have questions or concerns about anesthesia, take a few minutes to explain the facts of modern anesthesia to build their confidence. Today's patients have more options, anesthesia is much safer and they experience fewer side effects. Plus, the entire anesthesia team makes patient safety a top priority before, during and after the procedure to ensure a successful, collaborative experience every step of the way.

For more information, contact John Rzyhak at 989.583.6237 (jrzyhak@chs-mi.com).

Infection, Immunodeficiency or Allergy? *What To Look For*

Dr. Jonathan Horbal, Allergy-Immunology, Midland and Bay Allergy Clinic

Patients who have been treated with strong antibiotics for persistent infections, yet show little recovery, could have an underlying allergy or primary immunodeficiency disease (PIDD) that make them more susceptible to infection. Per the Immune Deficiency Foundation, the population prevalence of diagnosed PIDD in America is estimated at approximately one in 1,200 people, with most patients not being properly treated.

It's easy to assume that a patient's immune system is intact when they present in the office or hospital. For some patients, however, the immune system fails to protect them properly, which may lead to chronic, recurrent, or severe and unusual infections. Unless properly diagnosed, this can cause ongoing health problems and serious illnesses.

Physicians should be suspicious when patients return to the office more often than normal. When treatments are not working and multiple organ systems are affected, it might be time to refer the patient to a clinical immunologist who can review the possibility of allergies **and** immune issues. This is true especially if patients present with two or more of the warning signs for PIDD shown in the sidebar to the right.

Types of PIDD

More than 350 PIDDs are recognized by the International Union of Immunological Societies. Two of the most common PIDDs, which primarily affect Caucasians, are:

- **Selective immunoglobulin A (IgA) deficiency (SIgAD)**. People with this genetic immunodeficiency lack the IgA antibody that protects against infections of the mucous membranes lining the mouth, airways and digestive tract. It strikes about one in 500 Caucasians and can increase the likelihood of allergies.
- **Common Variable Immune Deficiency (CVID)**. This genetic disorder is becoming more prominent, striking about one in 25,000-50,000 people – primarily adults. It is characterized by low levels of serum immunoglobins and antibodies, which increases susceptibility to infection, inflammatory and autoimmune disorders, and to lymphoma and other malignancies.

PIDD Testing and Treatment

The patient's personal and family history is key to understanding their condition. This should include insights about recurrent and chronic infections, types and sites of infections, and living and work environments.

Listening carefully to the patient ultimately reveals the diagnosis. It enables, for example, specialists to determine if the patient could have a PIDD, and to order the right blood tests to evaluate antibody deficiencies, cellular defects, neutrophil disorders and complement deficiencies.

Advances in genetic tools are identifying the genes responsible for most PIDDs, aiding both diagnosis and treatment. Currently, PIDD patients are generally treated as follows:

- For IgA deficiency, treatment is focused on treating the specific problem with targeted antibiotics and control of environmental allergies to address inflammation. Patients with chronic conditions may need these prescribed as a prophylactic.
- For CVID, treatment decisions are based on the clinical situation. Treatment can range from simple monitoring to chronic immunoglobulin replacement to relieve symptoms and avoid infections.

Summary

Patients who repeatedly present with a recurrent infection may have PIDD or a chronic allergy. The sooner their condition is diagnosed – especially in infants and children – the faster they can be treated to prevent future problems and ensure quality of life. Importantly, these patients can get the care they need locally in the Great Lakes Bay Region through a community of experienced clinical immunologists.

10 WARNING SIGNS of Primary Immunodeficiency (PI)*

The immune system is "total," affecting all organ systems, so think "immune" when more than one system is affected and patients have two or more of the following PI warning signs.

1. Four or more ear infections within one year
2. Two or more serious sinus infections within one year
3. Two or more months on antibiotics with little effect
4. Two or more pneumonia diagnoses within one year
5. Failure of infants to gain weight or grow normally
6. Recurrent, deep skin or organ abscesses (e.g. liver, lungs)
7. Persistent thrush in mouth or fungal infection on skin
8. Need for intravenous antibiotics to clear infections
9. Two deep-seated infections (e.g. septicemia, meningitis)
10. Family history of PI

**Jeffrey Modell Foundation*

For more information, contact Dr. Jonathan Horbal at 989.631.1010.


Treating Osteoporosis Prior to Spine Surgery

Dr. Amer Issa, Endocrinology, Covenant Medical Group and
Dr. Erich Richter, Neurosurgery, Covenant Medical Group

Osteoporosis treatment not only helps prevent fractures from occurring, but when they do occur, treatment can also improve surgical outcomes. The most common osteoporosis-related fractures are in the spine, hip, wrist or neck, with serious fractures often requiring surgery.

Patients with fragile bones, however, can face complications during surgery and recovery. In spinal surgery, for example, if an interbody cage is used to restore disc space height and the bone is too weak to hold it, it can subside into the vertebral body, causing a fracture. If pedicle screws are used to support fusion during healing, they can pull out. Also, if the health of the underlying bone tissue (even without implants) is poor, progression of the primary disorder could continue.

Such issues compromise the results of a variety of spinal procedures. In situations such as spinal fusion, the rate of healing is markedly inhibited and the chance of failure of fusion or hardware complications is increased. In other procedures, such as kyphoplasty or spinal decompression surgery, the risk of structural failure around the surgery is higher, increasing the risk that additional surgeries such as fusion will be needed to correct the complications.

The Burning Platform

According to the National Osteoporosis Foundation, more than 54 million people in the United States have osteoporosis (10 million) or are at high risk of the disease due to low bone density (44 million). Studies show:

- In the population aged >50 years that required spine surgery, the reported incidence of osteopenia was 46.1% and 41.4% for men and women respectively, and the incidence of osteoporosis was 14.5% and 51.3% for men and women respectively.
- Many high-risk patients remain untreated, likely due to a combination of their concerns about medication side effects, resistance to lifestyle changes and lack of medical follow-ups.
- The economic toll is high too, with costs expecting to rise from $57 billion in 2018 to over $95 billion in 2040 unless preventive strategies are implemented.

Treatments

Several options are available to build bone density, including pharmacological interventions and changes in diet and lifestyle. Ideally, the patient's physician will diagnose low bone mineral density (BMD) via a DEXA scan, treat the patient before problems occur and then follow up to ensure progress.

When surgeons don't have BMD information, many will test for osteoporosis as part of the pre-operative process. Recommendations are to start treatment upon diagnosis for four to six weeks pre-operatively (if possible), and continue treatment after surgery. That said, delaying elective procedures for improvement of BMD is not an option for many patients as improvement takes time and it is not always reasonable to wait.

The choice of pharmacological treatment is usually individualized to the patient and depends on multiple factors. These include the severity of osteoporosis, secondary causes, other comorbidities, the well-being of the patient and their frailty score. It is worth mentioning that, in general, treatment with recombinant parathyroid hormone has a more preferred outcome than other osteoporosis drugs in this population.

Actions

A large gap exists between the number of patients who sustain fragility fractures (including vertebral fractures) and those who receive timely treatment for osteoporosis.

To close that gap, anyone experiencing hip or back issues, or a fragility fracture, should have an osteoporosis work-up to screen for secondary causes and get the proper treatment. This is true regardless of age or gender, and even before physical therapy is prescribed. These patients should also be monitored regularly to ensure their treatment plan is successful.

Such attention not only reduces a patient's surgical risk, but also significantly improves and potentially extends their quality of life.

For more information, please contact Dr. Issa at 989.583.5340 (amer.issa@chs-mi.com) or Dr. Richter at 989.752.1177 (erich.richter@chs-mi.com).

Osteoporosis Reminders

- Screen patients for potential osteoporosis risk; treat as early as possible.
- Follow 2019 clinical guidelines from the Endocrine Society for osteoporosis screening and treatment; follow up to ensure positive outcomes.
- Tailor the treatment plan to the patient, including medications, diet, exercise and lifestyle habits.
- Note that Medicare often pays for testing and FDA-approved drug treatments to ensure early prevention.

Ischemia: *Cardiac Evaluation for Women Presenting with Chest Pain*

Dr. Pauline Watson, Cardiology, Covenant Medical Group

Cardiovascular disease (CVD) is the leading cause of death for American women. However, many women do not realize they are at risk and the signs are often missed, partly because women present and test differently than do men. Proper and earlier diagnoses help decrease mortality and complications.

The Risk in Women

Women have a later onset of CVD than men, with initial CVD manifestation occurring 10 years later and myocardial infarction (MI) up to 20 years later.

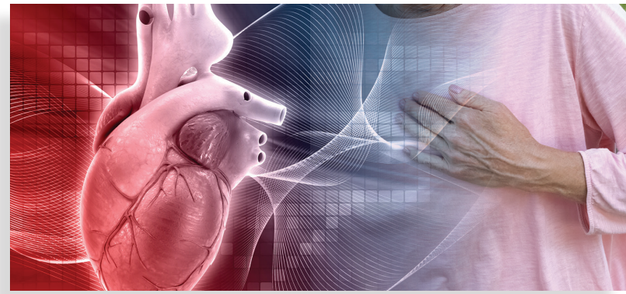
Despite the lower prevalence of CVD in younger women, the consequences of premature coronary heart disease are relatively worse. Data show a two-fold increase in mortality after acute MI in women less than 50 years old compared with men of the same age, and a five-fold higher mortality rate in younger women compared with younger men.

According to the American Heart Association (AHA), one in three adult women have CVD and women at risk for coronary artery disease (CAD) are referred less often for diagnostic tests than are men. Lack of CVD awareness among women **and** the medical community are viewed as barriers to diagnosis.

Key Test Methods

The spectrum of CAD includes obstructive, non-obstructive microvascular or endothelial dysfunction. Four non-invasive tests are used to assess CAD, measuring heart performance at rest and after it has been stressed with exercise or medication.

- **Exercise Treadmill Test (ETT) with Electrocardiogram (ECG):** The American College of Cardiology (ACC) and the AHA recommend this as the test of choice for women with *intermediate risk* of CAD who present with chest pain, whose ECG is interpretable and who can exercise >5 METS[1]. It provides prognostic information, functional capacity, blood pressure and heart rate response. However, there are gender-specific factors that can diminish testing accuracy. The Duke Treadmill Score – which uses exercise capacity, ST segment change and angina score – improves the predictive value in women. A positive ECG in women indicates that further testing is necessary.
- **Exercise Stress Echocardiogram (ECHO):** This ultrasound test is performed using the treadmill or stationary bicycle to increase heart rate. It detects the presence of left ventricular systolic or diastolic dysfunction, valvular heart disease, and the extent of infarction and stress-induced ischemia. The AHA recommends this as the test of choice for women who are *symptomatic and at intermediate to high risk* of CAD.
- **Dobutamine Stress Echocardiogram (DSE):** This test is used for patients unable to exercise; the drug is a commonly used stress agent that causes the heart to beat faster. It is recommended for women with *normal or abnormal ECG results who are incapable of exercise,* providing superior diagnostics over ECG.



- **Stress Myocardial Perfusion Imaging (MPI):** This "nuclear stress test"" uses scintigraphy and single-photon emission computerized tomography (SPECT) to analyze heart function via 3-D imaging. It is recommended for women who *cannot exercise,* revealing perfusion defects, global, and regional left ventricular function and volumes.

Diagnostic Challenges

When compared with men, women:

- Demonstrate a lower prevalence of CAD and less predictive/atypical symptoms.
- Tend to be older at the time of diagnosis, potentially limiting their tolerance to exercise.
- Face many factors affecting test accuracy, which range from higher prevalence of non-obstructive CAD and single-vessel disease to a lesser increase in left ventricle ejection fraction, hormonal influences of estrogens and smaller coronary arteries.

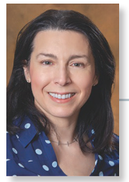
In addition, women tend to present with seemingly unrelated symptoms, including neck, shoulder, back and abdominal discomfort, shortness of breath, pain in one or both arms, nausea or vomiting, sweating, dizziness, unusual fatigue and indigestion.

Talking To Patients

Primary care physicians and their staff play a unique role in educating female patients that heart disease does not discriminate. If a patient presents with symptoms suspected to be due to CAD, ask questions and listen carefully. If warranted, order a study or refer them to a cardiologist, especially when there is an elevated risk for heart disease. This will help establish a basis for diagnosis and therapeutic intervention.

For more information, contact Dr. Watson at 989.583.4700 (pwatson@chs-mi.com).

[1]*Metabolic equivalents of task*



Bronchodilators for Respiratory Diseases: *How To Improve Outcomes*

Dr. Sophie Toya, Pulmonology, Covenant Medical Group

Two key respiratory diseases, asthma and chronic obstructive pulmonary disease (COPD), have been on the rise since the early 1980s, largely due to environmental factors. Today, more than 25 million people have asthma and nearly 15 million have COPD, placing a huge burden on patients, families and the economy.

One common treatment is bronchodilators (inhalers), which dilate the airways to keep them open. The problem, however, is that the majority of patients using inhalers do not know how to use them and have not had their technique routinely checked by a clinician.

Misuse of Inhalers

Unfortunately, incorrect inhalation technique is fairly common. The error rate can be as high as 66.5%, depending on whether they are using a metered-dose inhaler (MDI), dry-powder inhaler (DPI) or soft-mist inhaler (SMI).

Misuse of any inhaler is the main reason why patients can't get control over their asthma or COPD. It can also:

- Lead to continued morbidity, office visits and hospitalizations, which can result in patient dissatisfaction and depression.
- Trigger serious flare-ups, as the medication is not adequately reaching the lungs.
- Increase the risk of side effects like dysphonia and oral thrush.
- Cause death. The Asthma and Allergy Foundation of America states that 10 people die per day from asthma alone and that most deaths are avoidable with proper treatment and care.

Patient Education

Studies show that most patients and clinicians view the class of medication as more important than the inhalation device or technique. Patients who receive device training, however, are much more satisfied with the results – reinforcing the impact of device education on treatment success.

If you have patients using inhalers, take the time to:

- Ensure that the inhaler type is appropriate for the patient's age, developmental stage and dexterity. If they have issues, then consider switching to another type of device.
- Ensure that the patient is receiving the right type of medication. If it is not yielding the desired outcomes, check the inhaler technique **before** increasing the medication.
- Re-educate yourself and relevant staff on the proper use of inhalers and the various types.
- Routinely teach and re-evaluate patients at every visit because patients do forget. Competent staff can also assist with education. This should be hands-on, individualized training in which the educator assesses the patient's technique in action, uses a checklist to identify issues, then explains and demonstrates proper use.

The top five inhaler mistakes include failure to:

- Attach inhaler to a spacer.
- Exhale fully prior to inhalation.
- Inhale too fast or not deep enough.
- Hold breath for 5-10 seconds after inhaling.
- Shake inhaler before use.

Summary

Just as diabetics receive training on how to inject insulin, so should respiratory patients get repeated training on how to use inhalers. This is proven to enhance outcomes and can even reduce the need to switch or increase medications. Clinicians can also refer patients to a pulmonologist if they are not comfortable with educating patients about their device or treating them for respiratory disease.

For more information, contact Dr. Toya at 989.583.7380 (sophie.toya@chs-mi.com).

Inhaler Guidance

Clinicians should carefully review detailed instructions for each inhaler. Below are a just a few points to consider:

- MDI: This handheld device uses a chemical propellant to release a puff of medicine when a canister is pressed. **Challenge:** Coordinating the inhaled breath with the release of the medicine. A spacer can be used to assist if needed.
- DPI: As a dry-powder inhaler, this operates like an MDI but without a propellant. Instead, an inward breath activates the medicine, negating the need for coordinating breaths or using a spacer. **Challenge:** The patient must breathe in harder and doses may not be exact. DPIs can also be affected by environmental factors.
- SMI: This device creates a cloud of medicine that is inhaled without a propellant. Because it contains more particles of medicine than MDIs and DPIs, more of the drug enters the lungs. Coordinating breaths or using spacers are not needed. **Challenge:** Not many drug combinations are currently available.

Improving Surgical Services and Patient Satisfaction

Dr. Todd Richardson, General Surgery, Covenant Medical Group and
Aimie Goodrow, Surgical Services/Ambulatory Director, Covenant HealthCare

Surgery can be a stressful time for many patients and their families. To ensure high-quality patient care and a positive patient experience, many hospitals nationwide are improving the way surgical services are delivered.

Key drivers of success include:

- Collaboration and teamwork across the entire care team to coordinate care and smoothly prepare the patient for every step of their surgical journey.
- Communication and education for patients and providers to promote understanding and efficiency, including pre-operative concerns around anesthesia, surgery and recovery.
- A streamlined process that adds value at each step of the process – from admissions to discharge and post-operative needs – while enhancing patient safety.

These and other patient-centric efforts are proving to enhance overall patient satisfaction, not to mention the reputation of the healthcare providers serving the patient. Below are some specific ways Covenant HealthCare is making strides.

What Covenant Is Doing

Recognizing the need to modify how patient care is delivered, a team of representatives from specialty offices and departments across Surgical Services met at a week-long event last spring. This event was geared toward understanding patient flow and improving delivery of care.

The team identified several opportunities to promote the patient experience and gain process efficiencies, including:

- **Improving surgical scheduling and timely delivery of patient care.** The team noted that gaps in the scheduling and surgical preparation processes were causing delays and cancellations – a source of inefficiency and frustration among staff, surgeons and patients.
- **Enhancing patient and office communications.** Abnormal labs, along with patient confusion about medications, pre-surgery preparation and surgical clearance (e.g. understanding surgical risks and needs for further evaluation or treatments) were leading factors behind surgical delays and cancellations. Mix-ups about arrival location and pre-operative wait times rose to the top as key issues impacting patient flow and satisfaction.

Acknowledging these concerns, the team agreed to develop a standardized process to enhance the entire surgical journey. It started by updating surgical workflows, pre-operative instructions, discharge instructions and patient facility maps. The team validated these updates by:

- Getting constructive feedback from the Patient Family Advisory Council (PFAC). This forum of patients and family members provided valuable insights along with a reminder to focus on the patient's foremost priority, which was: "To feel listened to and have their concerns validated."

2019 NATIONAL PATIENT EXPERIENCE SURVEY: COVENANT SURGICAL SERVICES*

	Large Database Percentile Rankings		
	APRIL 1 - JUNE 30	JULY 1 - SEPT. 30	OCT. 1 - DEC. 12
Covenant Surgical Services Rating	37%	61%	70%
Patient Received the Needed Procedural Information	31%	75%	75%
Procedural Information Is Easy to Understand	18%	67%	67%
Surgical Preparation Instructions Are Good	66%	76%	74%
Anesthesia Side Effects Are Easy to Understand	35%	45%	80%

** From a Press Ganey Patient Experience survey comparing Covenant Surgical Services (Harrison Ambulatory/Operating Room) to hospitals greater than 100 beds nationwide.*

- Using PFAC feedback to further enhance patient instructions, maps and surgical workflows, and to reduce duplication between each transition of care. Working with the Information Technology group, for example, has empowered the care team to view all patient documentation entered into the system. This helps ensure patient safety, avoids repetitive questions to the patient and improves efficiency.
- Improving how we communicate with the patient's family, who plays a large role in post-operative patient care. Collaborating with an electronic medical records (EMR) analyst, for example, has enabled the care team to text real-time alerts about the patient's status with each transition of care.

These and other improvements are already getting positive feedback from patients and care teams alike. As shown in the table above, patient ratings on several aspects of care significantly improved from April through December. Patients are now perceiving their Covenant experiences as better than the national average. In addition, from July through December, avoidable cancellations were cut in half.

Going Forward

Today's patients seek to be fully informed about their healthcare options, and providers should always be striving to stay a step ahead. In the surgical realm, this means addressing top patient concerns while ensuring that every step forward in efficiency is also a step ahead in patient safety and satisfaction. This can only happen through collaboration, teamwork and a sharp focus on extraordinary care.

For more information, contact Aimie Goodrow at 989.583.4674 (agoodrow@chs-micom).

COVENANT HealthCare

Extraordinary care for every generation.

Covenant HealthCare
1447 North Harrison
Saginaw, Michigan 48602

Non Profit Org.
U.S. Postage
PAID
Saginaw, MI
Permit No. 447

The Covenant Chart is published four times a year. Send submissions to:
Jennifer Behm, Physician Liaison
jennifer.behm@chs-mi.com
989.583.4051 Tel
989.583.4036 Fax

The Chart Spotlights

Congratulations Physicians of the Month!

Your patients and colleagues are saying extraordinary things…

JANUARY
Dr. Pramod Kalagara
HOSPITAL MEDICINE

"Thank you, Dr. Kalagara, for leading a project to improve the patient experience. Your efforts will make a difference in many patients' lives."

"Dr. Kalagara is a very, very nice doctor with a great bedside manner."

"Dr. Kalagara did an excellent job of explaining things to me."

FEBRUARY
Dr. Therese Mead
EMERGENCY MEDICINE

"Dr. Mead was exceptional in her care for me. She totally understood my situation."

"(She is the) best doctor I've experienced or ever witnessed."

"I was very comfortable with my doctor."

MARCH
Dr. Anushiya Kandiah
INTERNAL MEDICINE

"It's the very best care I've seen in a while. The nurses and doctors are efficient. They (Dr. Kandiah and staff) are very caring and compassionate people."

"Dr. Kandiah brought clothing from home to give to my homeless patient. She is so amazing!"

"Dr. Kandiah was wonderful."

Tip for Patient Success

"I believe that every physician at Covenant HealthCare does an excellent job caring for our patients. I find that achieving a better patient experience involves spending time listening to the patient and making them feel involved in decisions about their medical care."

Dr. Bashar Al Jayyousi
Cardiology
September 2019 Physician of the Month