THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | MARCH 2021

How COVID-19 Can Ignite Positive Change

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

The past 12 months have turned our lives upside down. As physicians, we pushed on despite our own sense of loss of control from not knowing how long we would be dealing with the pandemic and its numerous consequences.

Mental health experts told us that anxiety was a normal outcome from this ordeal. Everyone has felt it to varying **degrees**, including our patients. However, it has also ignited positive changes that otherwise would not have occurred as quickly – changes that can help reduce anxiety. Two examples are below.

Acceptance of New Technologies

The rate of adoption is how fast a new technology is acquired and used by the public. Quite often, the public needs to first accept the value of the new option before moving away from whatever currently exists. For example, adoption of telehealth was slow to catch on but during the pandemic, it has been a blessing on many levels. Patients appreciate the easy, safe access to healthcare providers while providers appreciate the convenience and ability to deliver continued care. Hopefully, this acceptance will spill over into other medical advances that we have yet to imagine, making quality healthcare even more available in the future.

Awareness of Quality Communications

The growing awareness of quality communications has been another important outcome of this pandemic. We've experienced a lot of barriers – masks, shields, social distancing, office closures, quarantines and other pandemic-related stressors that have made patients feel isolated from physicians and vice versa. We can, however, get around those challenges by taking the time to truly listen and communicate to each other with kindness, patience and focus.

Research on how quickly physicians interrupt patients when gathering their medical history is eye-opening. An article in the *Journal of General Internal Medicine* (2019) looked at this exact issue, stating that "… patients who had the chance to explain their symptoms were still interrupted seven out of every 10 times within an average of 11 seconds from when they started speaking."

This begs the following self-directed questions:

- **Is this how you listen to patients and what if the tables were turned?** As a patient, would YOU like to be constantly interrupted when sharing your thoughts and fears? We can do better with our time.
- **If someone recorded your communications with colleagues, would you be viewed as a respectful listener?** For example, when you call consultants in another department, do you jump ahead too quickly so as not to waste time, even though that extra minute could promote better teamwork and outcomes?
- **Can you improve your dialogue?** We are moving more and more to using texts and digital methods (e.g., Vocera and PerfectServe), which further remove the human voice and verbal cues from communication. I hope we never lose our abilities to actually speak to each other because verbal conversations are proven to strengthen relationships, avoid miscommunications and make people more attentive.
- **Are you honing your non-verbal skills too?** Most experts agree that at minimum, 70% of all communication is nonverbal. While we can't give people a reassuring touch during this pandemic, we can work on other "bedside manner" cues, such as leaning forward when we talk, using hand gestures, nodding our head, maintaining good eye contact, and holding an open posture while speaking in warm, clear vocal tones.

I am making 2021 a year for enhancing my communications and achieving personal renewal. My goal is to build on the learnings from 2020 to preserve the human element while delivering health and wellness to patients, family, friends, colleagues, community – and yes, to myself as well.

I hope you will join me on this endeavor and am happy to discuss with you further. Feel free to give me a call.

Sincerely,

K Cowling

Dr. Kathleen Cowling

CONTENTS

Neoadjuvent Systemic Therapy in Inflammatory Breast Cancer 2
Update on Cures Act Compliance 3
Doctors' Day 2021 3
How Early Neurogenic Bowel and Bladder Programs Help Control and Prevent Pressure Injuries 4
When and How to Request LifeNet of Michigan Air Transport 5
Success Stories Support Neurostimulation for Complex Pain 6
Kudos to Covenant HealthCare for 2020 Leapfrog Awards and Vaccine Progress! 7
The Chart Spotlights: Physicians of the Month 8

Neoadjuvent Systemic Therapy in Inflammatory Breast Cancer

Dr. Sussan Bays, Breast Surgeon, Covenant Medical Group

Inflammatory breast cancer (IBC) is an uncommon but aggressive subtype of breast cancer contributing to nearly 10% of breast cancer deaths. One in three patients diagnosed with IBC presents with distant metastases (stage IV). Historically, IBC was fatal.

Major advances have been made by introducing an interdisciplinary approach to the treatment of IBC which begins with neoadjuvant systemic therapy – also known as neoadjuvant chemotherapy – along with surgery, adjuvant radiation therapy, HER2* targeted therapy or hormone therapy as appropriate.

But first, effective treatment relies on rapid and accurate diagnosis.

Recognizing Inflammatory Breast Cancer

With inflammatory breast cancer, there is often no palpable mass. It is characterized by florid tumor emboli that obstruct dermal lymphatics, leading to inflammation and swelling in the affected breast.

Clinical presentation of IBC may include:

- Rapid onset of diffuse breast erythema
- Peau d'orange edema
- Skin changes occupying as much as two-thirds of the breast
- Pain and tenderness
- Warmth and heaviness
- Nipple inversion and/or discharge
- Axillary and/or supraclavicular lymphadenopathy

Though many of these signs and symptoms are similar to an acute breast infection or abscess, **physicians should suspect IBC especially for non-lactating women**.

After taking a thorough history and physical if not already available, and a baseline photograph, your first course of treatment will be a trial of antibiotics to see if symptoms decrease. If they do not, consider malignancy and either:

- Order further studies, such as bilateral diagnostic mammography, bilateral breast and nodal ultrasound (US), bilateral breast MRI (if US and mammogram are not diagnostic), US-guided core biopsy of tumor (or MRI-guided biopsy if mass not present), or
- Plan to work with a breast specialist to guide this process.

Be aware that those at greatest risk for IBC are women in their 40s and 50s (although men can also have IBC), as well as women who are African American and/or obese. Note: Younger pregnant and breastfeeding women can and do develop IBC.

Benefits of Neoadjuvent Systemic Therapy

In locally advanced breast cancers like IBC, a combination of neoadjuvant chemotherapy, surgery and locoregional radiation therapy offers the highest likelihood for a successful long-term outcome.

The purpose of administering neoadjuvant chemotherapy in nonmetastatic (stage III) IBC is to downstage the disease:

- Converting a previously unresectable, locally advanced breast cancer to an operable tumor
- Allowing for less extensive surgery on the breast and/or axilla
- Improving cosmetic outcomes
- Reducing post-operative complications such as lymphedema
- Preventing metastatic disease

In the case of stage IV IBC, our goals are to prolong survival, reduce treatment-related morbidity as much as possible, and gain local control and palliation of symptoms.

Neoadjuvent chemotherapy also provides the treatment team with information about treatment response which can be used to guide adjuvant therapy. In addition, the presence or absence of residual invasive cancer after neoadjuvant therapy is a strong prognostic factor for risk of recurrence, especially in triple negative and HER2 positive cancers.

Most neoadjuvant therapy used in the United States is anthracycline-based with a taxane. A large retrospective study from MD Anderson reported that 178 IBC patients treated with upfront anthracycline-based chemotherapy, combined with radiation therapy with or without mastectomy, had an objective response rate of 74%, a median survival of 37 months and a 10-year survival rate of 33%.

Conclusion

Inflammatory breast cancer is not a typical breast cancer, but is one to watch for vigilantly. Be suspicious when a patient presents with a painful, inflamed breast and isn't breastfeeding, isn't feverish and on whom antibiotics have been unsuccessful in resolving symptoms. Instead, reach out to a breast specialist immediately for a consultation. Since IBC can spread in weeks, swift action and collaboration can preserve breasts and save lives.

For more information, contact Dr. Bays at 989.583.5195 or sussan.bays@chs-mi.com.

**HER2 = Human Epidermal Growth Factor Receptor 2*

MD Anderson Inflammatory Breast Cancer (IBC) Registry

As part of MD Anderson's Cancer Network, Covenant HealthCare will be a participating site in an ongoing study to better understand the biological features of IBC. The resulting data, pathology and images will be used to help develop more sophisticated diagnostic technologies at the genomic and protein level. To determine patient eligibility, contact the author at your convenience.

Update on Cures Act Compliance

Dr. Aaron Smith, Chief Medical Informatics Officer, Covenant HealthCare

In the December 2020 edition of *The Covenant Chart*, we covered the impact of the 21st Century Cures Act on healthcare. The goal of this act is to improve the quality and efficiency of patient care by ensuring patient access to their electronic health information (EHI). As shown in the visual below, EHI must be available to patients on demand, which means that information blocking must be prohibited.

Despite COVID-19, many healthcare organizations have started paving the way to easier EHI access (with few exceptions). Indeed, providing easier access is even more important during this time of social distancing. Covenant HealthCare, for example, is implementing a staged adoption of several information technology changes. Below is a current timeline:

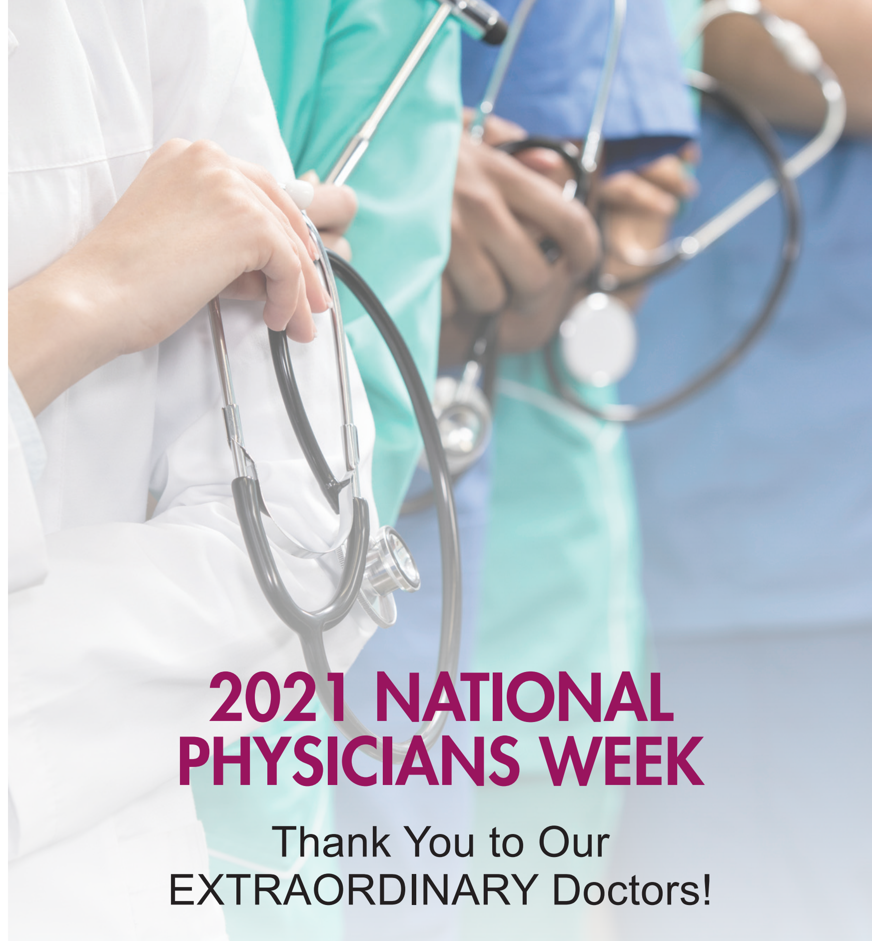
- February 1: Laboratory Results changes were successfully implemented.
- March 1: Initiated the release of all Physician/APP Clinical Notes to the patient as the note is signed. Recent guidance from the government allowed us to focus on the release of notes that are the most clinically relevant. For more information, see https://covnet.covenanthealthcare.com/global/cures-act.aspx.

These two changes will bring Covenant into compliance with the initial aspects of the Cures Act. You will be kept informed about other changes, which will likely occur next year.

For more information, contact Dr. Smith at 989.583.6256 or aaron.smith@chs-mi.com.

On-Demand Electronic Health Information

- Allergies
- Assessment/Plan of Treatment Notes
- Care Team Notes
- Clinical Notes
- Demographics
- Goals
- Health Concerns
- Immunizations
- Lab Results
- Medications
- Problems
- Procedure Notes
- Provenance
- Smoking Status
- Unique Device Identifiers for Implants
- Vital Signs



2021 NATIONAL PHYSICIANS WEEK

Thank You to Our EXTRAORDINARY Doctors!

National Physicians Week serves as an opportunity each year to celebrate the phenomenal physician providers at the core of Covenant HealthCare. YOU help our entire healthcare team shine! Our gratitude is felt every single day as countless acts of your compassion and care to Covenant patients are witnessed by others. You bring invaluable talent, creativity and collaboration to the halls of Covenant HealthCare.

Our Covenant physicians are men and women possessing great heart, soul and resilience, especially this past year as you helped lead the way through the COVID-19 pandemic. Your ability to balance the human element of caring and respect with the professional aspect of treating ailments is a core reason why Covenant HealthCare is a leader in our community and the healthcare industry. Because of you, we can all bring extraordinary care to every generation.

We recognize you, our physician body, as one of Covenant's strongest resources. Together, on an annual basis, you care for around 27,000 inpatients, and handle about 90,000 visits to the Covenant Emergency Care Center and about 100,000 visits to locations in the Covenant MedExpress network. We are fortunate to have such incredible physicians and understand it does not come without a personal cost.

This year for Physicians Week, we want to honor your service with gestures that support physician wellness. So please join us as we recognize Doctors' Day throughout the week!

Tuesday, March 30
Doctors' Day: Receive your "Wellness Snack Pack!"

Wednesday, April 1
"Mask-Up" for Your Health!

Thursday, April 2
Prize Basket Drawings

Friday, April 3
Delivery to the Basket Winners with a "Quick Pic!"

How Early Neurogenic Bowel and Bladder Programs Help Control and Prevent Pressure Injuries

Dr. Jennifer Weekes, Physical Medicine & Rehabilitation, Mary Free Bed at Covenant HealthCare

Patients who have neurogenic bowel and bladder due to a spinal cord injury or other neuromuscular conditions (e.g., multiple sclerosis, amyotrophic lateral sclerosis, spina bifada) are at increased risk to have issues with incontinence. This, in turn, can lead to social and emotional problems along with serious infections – all of which impinge quality of life and interfere with effective medical care.

Recognizing and Preventing Wound Issues

Ongoing issues with incontinence can cause wound dressings to become soiled, requiring frequent dressing changes and potential infections if not addressed in a timely manner. Incontinence also creates moist environments that can cause and/or worsen pressure injuries – especially in the buttock area (coccyx and sacrum). However, the risk of such problems can be greatly reduced by:

- Establishing a neurogenic bowel and bladder management program immediately after diagnosis of the nerve-damaging condition, or early in the hospital stay for patients with known or chronic conditions.
- Engaging the Physical Medicine & Rehabilitation staff (PM&R) as early as possible whenever an acute-trauma patient is admitted, or when a patient with neurogenic bowel or bladder is admitted.
- Paying attention to high-risk factors, such as complaints of constipation, diarrhea, loss of bowel and bladder control, absence of bowel sensation, nausea, belly pain, leakage of urine and feces, and accidents.

Such actions will help control and prevent further issues. When physicians engage with PM&R early in the process, it provides a more holistic picture of the patient's condition that can ensure a smoother recovery and transition to a post-acute setting such as inpatient rehabilitation (IPR). Occasionally, for example, chronic wounds are present prior to hospital admission and patients may not be aware they even have a serious wound unless noticed by medical staff. Increasingly, however, patients with severe injuries are presenting later, when they arrive to IPR, with a new onset of preventable pressure injuries due to prolonged hospitalization. Catching these issues before they result in a set-back is critical to improving patient outcomes, as exemplified in the case study shown below.

Early Intervention Case Study

A patient presented to the inpatient rehabilitation unit after a prolonged hospitalization, suffering from acute complete paraplegia secondary to cord ischemia following a cardiac arrest. He was in acute care weeks prior to a PM&R consult. Upon arrival, he had multiple wounds including a coccyx pressure injury, which was initially made worse due to persistent incontinence. PM&R worked early in his stay to establish a bowel program. If PM&R had been consulted in the acute care setting, however, the bowel program could have been initiated sooner, which may have reduced its severity. This, in turn, would have reduced pain and discomfort while improving speed of recovery.

Creating an Effective Management Program

PM&R can provide a comprehensive assessment of the patient to determine the type of bowel and bladder pattern that is present. Based on that evaluation, they can make recommendations to design a custom, neurogenic bowel and bladder management program in the acute care setting. This may include the following.

Non-pharmacological Therapy

- Abdominal massage and muscle training, plus exercise and activity plans.
- Dietary changes
- Transanal irrigation and/or enema
- Scheduled bowel routine
- Digital rectal stimulation
- Manual disimpaction
- Managing neurogenic bladder with intermittent straight catheterization or Foley (if absolutely needed) to keep the perianal area dry and limit development or worsening of pre-existing pressure injuries.

Pharmacological Therapy

- Stool softeners
- Osmotic laxatives
- Stimulant laxatives
- Bulk-forming laxatives
- Prokinetic agents
- Suppositories

Surgical Treatment

For patients with long-term or chronic issues with neurogenic bowel who have failed conservative treatments, PM&R can help coordinate consultations for potential surgical considerations, such as:

- Colostomy surgery to divert bowel
- Sacral neuromodulation can also be helpful (see the article by Dr. Rajpurkar in *The Covenant Chart*, December 2020).
- Malone antegrade continence enema

Summary

Early and effective communication across medical specialties will result in the best possible outcomes for patients. Initiating a comprehensive program early in the acute setting for patients experiencing neurogenic bowel will help minimize undesired clinical outcomes related to preventable pressure injuries.

For more information, contact Dr. Weekes at 989.583.2130 or jennifer.weekes@chs-mi.com.

When and How To Request LifeNet of Michigan Air Transport

Dr. Michelle McLean, Medical Director for LifeNet of Michigan, Covenant HealthCare

Air ambulance transport is sometimes ordered to treat critically ill or injured patients when a land ambulance cannot reach the patient for urgent treatment due to, for example, poor road conditions, traffic or inaccessibility. Ambulance support may also be used to transfer patients from a hospital to a specialized care facility, such as a burn center, if such care is not available at the sending hospital.

Major hospitals across the nation, including Covenant HealthCare, typically contract the services of medical air transport companies to improve patient survival. Who, when and why do you call to help patients in the Great Lakes Bay Region? Below is some useful guidance.

When To Call LifeNet of Michigan

Physicians requiring high-level, critical patient care and swift transportation should specifically request LifeNet of Michigan by calling central dispatch at 1.877.606.1225 to request assistance. LifeNet will transport these patients to Covenant HealthCare or directly to another receiving hospital if needed.

Patients who are critically ill or suffering traumatic injuries, and who require ventilator management, medication administration, blood administration, medication drips and/or sedation, may qualify for air transport. At LifeNet, air ambulance care is provided by a skilled team of two skilled providers, a paramedic and a nurse.

Note that sending physicians are responsible for the patient until he/she arrives at the receiving facility. Air ambulance transport is usually subject to the same insurance regulations as ground ambulance, such as copays and deductibles.

Why Call LifeNet of Michigan?

Some physicians mistakenly think that they should use the transport services of the receiving hospital. LifeNet of Michigan, however, is local, convenient and fast, offering the following advantages:

1) **A trusting partnership.** In 2005, Covenant entered a partnership with LifeNet of Michigan and their parent company, Air Methods Corporation, to bring air medical ambulance transport to the region. Since then, it has grown into an established means for transporting critical-care patients to the most appropriate treatment destination. LifeNet also serves regional referral hospitals in the mid-Michigan, Thumb and northern region of Michigan's lower peninsula.

2) **A long arm of experience.** LifeNet has transported over 4,550 patients in the region, or approximately 300 per year. This includes over 200 NICU neonates and 550 pediatric, 300 adult STEMI and 1,200 adult trauma patients. Licensed to fly over water, LifeNet has also transferred patients out of our regional service area.

   The LifeNet of Michigan team includes eight critical care clinicians who provide patient care on the aircraft. They receive quarterly training, including didactic lectures, written tests and human patient simulation. They have the capability to provide blood products, vasopressor drips, medication administration and in many cases, complex ventilator management. Most of these clinicians have worked in the ICU prior to joining the LifeNet team.

3) **Convenient, fast response.** The large air frame used by LifeNet of Michigan is a BK117 twin engine aircraft located in the hanger just outside the Covenant Emergency Care Center (ECC) and helipad. The helicopter can be mobilized within minutes after air transport is approved, and has the capability, depending on weather, to lift 550 pounds in addition to crew weight. It is available 24 hours a day, 7 days a week and can reach any part of the service area in 30-60 minutes.

4) **Reliable leadership.** Air Methods is the largest civil operator of air ambulance helicopters, with over 450 aircraft flying under the highest degree of safety standards. They employ over 4,900 employees with a range of backgrounds including aviation, maintenance, business and clinical. Being a part of Air Methods provides structure and leadership to the LifeNet of Michigan program at Covenant.

The next time you need air ambulance transport for your patient, be sure to call or request LifeNet of Michigan first, for all the reasons stated above. Whether it is transferring a patient to or from Covenant, your patient will be in good hands.

For more information, contact Dr. McLean at 989.583.4763 or mmclean@chs-mi.com.

Success Stories Support Neurostimulation for Complex Pain

Dr. Erich Richter, Neurosurgeon, Covenant HealthCare

Dorsal root ganglion (DRG) stimulation was introduced in a December 2019 article of *The Covenant Chart* as an exciting treatment for patients diagnosed with chronic, intractable pain who do not respond to physical therapy (PT), behavioral management, nerve blocks or traditional spinal cord stimulation (SCS).

DRG stimulation is bringing hope to patients, helping them avoid larger surgeries, manage pain without narcotics and increase function faster. Candidates are evaluated with an MRI, followed by implantation of temporary electrodes in the spine to block pain signals during a one-week trial period. Most patients find dramatic relief, after which electrodes and leads are permanently implanted and programmed to the pain pattern. Patients control their therapy with a hand-held device.

The value of DRG stimulation rests in its ability to reach difficult areas that SCS cannot effectively treat, such as persistent neuropathic pain in the groin or knee after successful repair of a hernia or knee, the bottoms of feet in painful neuropathies, or perplexing back pain.

Below are two case studies describing how DRG stimulation has helped patients overcome chronic pain. Procedures took about 1.5 hours and recovery 3-4 weeks.

For more information, contact Dr. Richter at 989.752.1177 or erich.richter@chs-mi.com.

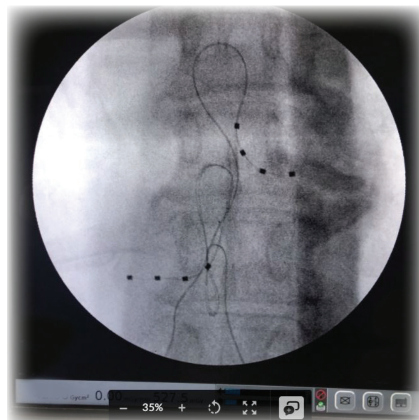
Thoracic Case Study of Patient with Back Pain

Challenge: A middle-aged woman presented with severe pain across the mid- to upper back, and more than 25 years of idiopathic thoracic radicular pain. She has a long history of multiple spine problems with successful surgical corrections in her cervical and lumbar spine. However, she also had persistent bilateral thoracic radicular pain despite relatively normal imaging, severely restricting her activities.

Previous Treatments: The patient failed injections and rhizotomies, had consulted with spine surgeons, failed PT, and had been managed unsuccessfully with oral narcotics. An investigation of traditional spinal cord stimulation was not helpful.

Treatment Solution: Implant two DRG electrodes in the thoracic spine. Because the pain was idiopathic, there was no anatomical indication of level, so on the day of trial electrode implantation, the patient and her family drew the pain pattern on her skin. Under anesthesia, temporary electrodes were placed over the dorsal root ganglia in that area. The pain responded to stimulation at the T8/T9 level with near complete relief.

Patient Comment: "I used to have pain 24 hours a day. I took Norco, Motrin and Tylenol all the time. Now, I have only taken about four Motrin in the past month. This procedure has given me nearly 100% pain relief."



DRG electrodes at T8 and T9 to treat back pain.

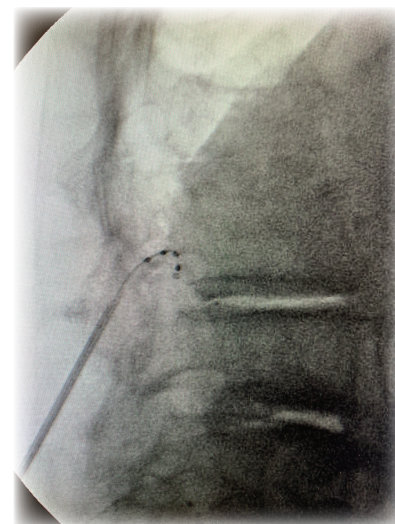
Lumbar Case Study of Patient with Knee Pain

Challenge: An elderly woman presented with L3 radiculopathy due to degenerative spinal deformity, compounded by dementia and hallucinations when taking medications. The patient could not ambulate due to chronic right knee pain.

Previous Treatments: The patient's bone quality was too poor for spinal surgery correction. Injections and PT also failed. The pain clinic could do nothing more.

Treatment Solution: Implant two DRG electrodes in the thoracic spine at L2 and L4 to control an L3 radiculopathy that could not be safely corrected with surgery or SCS due to age and comorbidities. DRG stimulation offered a safe procedural solution. Now the patient enjoys walks with her husband for more than a mile at a time. Both she and her husband have a better quality of life as a result.

Family Comment: "My mom's first (DRG) surgery was temporary to see if the procedure would work. The next day, she was walking more than she had in a year! The second surgery was permanent placement of the device. My dad programs it every morning and she is set for the day. We are thankful!"



DRG electrodes at L2 and L4 to control L3 radiculopathy and knee pain. While significant adhesions prevented placement of L3 electrodes, the area could be bracketed above and below the target level with electrodes to block pain.

Kudos to Covenant HealthCare for 2020 Leapfrog Awards and Vaccine Progress!

Dr. Michael Sullivan, Chief Medical Officer, Covenant HealthCare and
Aaron Feinauer, Outpatient Pharmacy Manager, Covenant HealthCare

Covenant Earns Prestigious Leapfrog Awards

The Leapfrog Group is a national organization focused on advancing healthcare quality, safety, and efficiency. Every year, it announces annual Top Hospital Awards and bi-annual Hospital Safety Grades based on information provided by hospitals in a voluntary Leapfrog Hospital Survey and on performance measures established by the Centers for Medicare & Medicaid Services (CMS) and other data sources. Leapfrog publicly reports hospital performance too, enabling consumers to make informed decisions, purchasers to find the highest-value care, and hospitals to benchmark their progress at keeping patients safe.

The entire Covenant HealthCare team should be immensely proud because, despite a year of immense pandemic challenges, your extraordinary commitment to healthcare quality and patient safety remained unwavering. As a result:

- **Covenant earned the 2020 Leapfrog Top Hospital Award for outstanding safety and quality.** Of 2,200 participating hospitals nationwide (about 400,000 inpatient beds), only 105 were selected as Top Hospitals.
- **Covenant is the only Michigan hospital to receive this award in the Top Teaching Hospital category this year, and has earned it two consecutive years.** This reinforces the strength of partnering with Central Michigan University (CMU) College of Medicine to teach future generations of physicians.
- **Covenant earned the Fall 2020 Hospital Safety Grade of "A" for the fifth time in a row.** This is the highest safety rating given by Leapfrog and is becoming the gold standard for measuring patient safety.

Top Hospitals have better systems in place to prevent medication errors, provide higher quality on maternity care, and achieve lower infection rates among other laudable qualities.

"Being recognized as a Top Hospital is an extraordinary feat and we are honored to recognize Covenant HealthCare this year," said Leah Binder, president and CEO of The Leapfrog Group. "Despite the extraordinary pressure and strain of the COVID-19 pandemic, Covenant HealthCare has demonstrated an unwavering dedication to patients and their community."

COVID-19 Vaccine Program Off to a Strong Start

Several FDA-approved vaccines are rolling off the lines and into waiting arms. Covenant received its first doses of the Pfizer/BioNTech vaccine on December 17 and held its first inoculation clinic that same day. Since then, it has held multiple clinics to quickly offer and administer the vaccine to employees and health partners.

Covenant aligns to the Michigan Department of Health and Human Services guidelines for inoculating people in Phases 1 and 2 of vaccination. Phase 1 is divided into three groups: Priority 1a, 1b and 1c for the most exposed and vulnerable, followed by Phase 2 (everyone else). For details, please see: *www.michigan.gov/documents/coronavirus/MI_COVID-19_Vaccination_Prioritization_Guidance_710349_7.pdf*

Below is a summary of Covenant activity through February 12 (including Mary Free Bed):

- Initial clinics were held on site at the main campus for Phase 1A. Collaboration with the Saginaw County Health Department and local retail pharmacy partners is enabling off-site, mass vaccination clinics and drive-through options for Phase 1B (followed by 1C and Phase 2).

Vaccine supply continues to be consistent, although still low. Meanwhile:

- Covenant urges Covenant and PHO employees in the Priority 1A group who have not yet been vaccinated to contact their leader or email COVID19Vaccine@CHS-MI.com for an appointment.
- All others (affiliated with but not employed by Covenant) can register with the Saginaw County Board of Health at *https://www.saginawpublichealth.org/*. Covenant is collaborating with them and local healthcare partners to coordinate vaccination appointments.

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

For questions about vaccines, contact Aaron Feinauer at 989.583.6484 or aaron.feinauer@chs-mi.com.

The Covenant team should be immensely proud of their extraordinary commitment to quality, safety and efficiency.

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: Amy Quackenbush, Marketing/Graphic Design Specialist, aquackenbush@chs-mi.com, 989.583.7652 Tel

©2021 Covenant HealthCare.
All rights reserved. PK 3/21 13610

The Chart Spotlights

Congratulations Physicians of the Month!

Your patients and colleagues are saying extraordinary things…

JANUARY

Dr. Tejal Joseph

FAMILY MEDICINE

"Dr. Joseph was amazing and has very good bedside manner. If I ever need anything again, I will be back to this MedExpress."

"Dr. Joseph was very professional and thorough. Her knowledge of my medical issues was impressive."

"The doctor and staff were all very professional and they have my highest regard for the way they worked with me."

FEBRUARY

Dr. Kathleen Cowling

EMERGENCY MEDICINE

"Dr. Cowling was so kind and caring. She wasted no time in making sure my son was comfortable. She was also honest and informative."

"Dr. Cowling was very through. I recommended her to my coworker."

"I will always use Covenant ER in the future for myself and my children considering the very positive experience we had."

MARCH

Dr. Hamsa Mohamed

HOSPITAL MEDICINE

"Dr. Mohamed and the nurses on Harrison 7 Main were exceptional."

"All the nurses and doctors that cared for me were wonderful; their kindness was beautiful. I will never forget them. Thank you very much."

"My stay was pleasant. Everyone was very caring and helpful. They went above and beyond. I have never seen people work so well together."