



Teaching the Future and Giving Back

*Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff*

In 1995, I was hired as core faculty in the newly formed emergency medicine residency program of St. Luke’s Hospital, which merged with Saginaw General Hospital to become Covenant HealthCare in 1998. Since then, when asked what I do for a living, I always answer with pride that “I teach doctors” before adding that I work in the emergency department.

A teaching mindset today keeps our knowledge alive tomorrow. This is why Covenant HealthCare and Ascension St. Mary’s signed a 25-year binding agreement last June to support Central Michigan University’s College of Medicine and our GME programs. This solidifies our commitment to our patients by promising to not only provide extraordinary care now, but to train the next generation to continue this mission with success.

Providing access to top-quality healthcare, however, goes beyond agreements like this. We ALL have the opportunity to educate residents and students. Examples include:

- Teaching them directly in classes or rotations, or acting as a mentor or coach.
- Offering preceptorships to students during their transition from “student” to practitioner.
- Delivering lectures or speeches at various educational events.
- Donating directly to various learning programs.

With physician leadership comes the responsibility to give back. Some people take the time to personally support, nurture, advocate and share their experiences and wisdom with those still learning the ropes. Others prefer to open their wallets to seed new learning programs, support current programs or enrich research initiatives. Taken together, these and other approaches can only amplify the impact on learning in ways that benefit us all.



Regardless of how you give back, the next time you think about what kind of educator you are, I hope you respond with one word: “Generous.” We’ve all worked hard and sacrificed a lot to get where we are, save lives, help others and “do no harm.” Just as we have stood on the shoulders of physicians who came before us and learned from them, let’s show our gratitude by doing the same for up-and-coming generations of physicians. Let’s be the shoulders they stand on by continuing to build a platform of learning, innovation and collaboration.

Such dedication has earned Covenant HealthCare the 2019 Top Teaching Hospital distinction from The Leapfrog Group. This is one of the highest honors American hospitals can receive, and Covenant is just one of five Michigan hospitals to receive it. All of you deserve a hearty applause for this accomplishment.

At Covenant, everyone learns – including the teachers who gain fresh perspectives from those they teach. Together, we become better physicians in ways that advance the world of medicine and drive a better future for our patients and communities.

Sincerely,

Dr. Kathleen Cowling

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Who Benefits from Patent Foramen Ovale (PFO) Closures?

Dr. Bashar Al Jayyousi and Dr. Manoj Sharma Cardiology, Covenant Medical Group, Structural Heart Center

The patent foramen ovale (PFO) is a flap-like opening between the right and left atrium of the heart that provides a pathway of blood/nutrients from the mother to the fetus. After birth it is no longer needed. It seals in about 75% of cases but remains open in 20-25% of the normal adult population.

Interestingly, PFOs have been found in 40% of patients with stroke. As a result, transcatheter PFO closure as a treatment for these patients has been studied extensively with multiple randomized trials, retrospective trials and meta-analysis to see if it could improve long-term outcomes.

Collective results show that, compared with medical therapy alone, transcatheter PFO closure can help prevent recurrent strokes in patients diagnosed with “cryptogenic stroke,” which is defined as a stroke with no clear, known origin. There are also some indicators that it could reduce the severity and frequency of migraines.

Overview of Trials

Two devices are typically used in the United States for PFO closure: Amplatzer™ and Gore®. Each underwent a randomized clinical trial (CLOSE and REDUCE respectively) to show that closing PFO with an occlusion device reduces the chance for recurrent cryptogenic strokes. The devices are inserted via a catheter to close the hole.

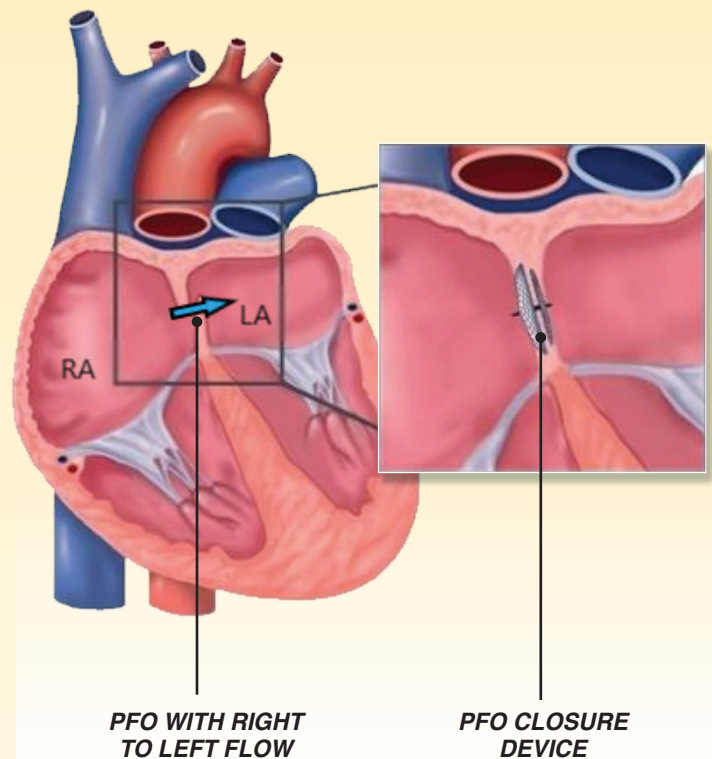
The Structural Heart Center at Covenant HealthCare is currently part of the Gore® REDUCE Post-Approval Study which – as the name implies – is a secondary, post-approval trial to study the safety and effectiveness of PFO closure with that device. The main goal is to show that the outcomes and experiences shown in the original, favorable REDUCE trial continue to yield positive results.

Patient Selection

A dominant consideration in all PFO closure studies is related to patient selection. Earlier trials did not show that PFO closure is beneficial, but this was likely due to lenient patient selection that was not confined to the cryptogenic stroke population.

Subsequent trials (CLOSE and REDUCE) used strict criteria to identify patients with cryptogenic stroke, eliminating any other cause after extensive evaluation – such as significant carotid artery disease or atrial fibrillation. Most important, the following criteria must be confirmed:

- The patient has no atrial fibrillation as indicated by heart monitors for at least 21 days or longer.
- There is no stenosis that is more than or equal to 50% in arteries supplying blood to the brain.
- The risk factors for stroke are controlled.
- The patient is younger than age 65.



Candidates for PFO Closure

The pathway to qualifying candidates for PFO closure should involve a multidisciplinary team that includes the primary care physician, neurologist, cardiologist, counselors and other stroke experts as needed.

Careful selection of patients with cryptogenic stroke, using the criteria stated above, will maximize the benefits of this procedure and thus help reduce stroke recurrence. In addition, transesophageal echocardiogram should always be done for patients with cryptogenic stroke to evaluate for PFO. Transthoracic echocardiogram on its own is not enough.

Per the REDUCE study, there is a 77% relative stroke reduction with PFO closure plus medical therapy, versus with medical therapy alone. For patients who have had an elusive “mystery stroke,” PFO closure may be a treatment option for them.

For more information, contact Dr. Al Jayyousi or Dr. Sharma at 989.583.4700 or at bashar.aljayyousi@chs-mi.com and msharma@chs-mi.com.



Avoiding Harmful Prostate Cancer Treatments with Advanced Diagnostics

Dr. Sanjeev Kaul, Urology, Covenant Medical Group

Aside from skin cancer, prostate cancer is the most common cancer in American men and a leading cause of cancer death in men. The challenge is to diagnose cases as early as possible, with minimal harm and maximum outcomes. This is critical because the incidence and mortality of prostate cancer is on the rise after a sustained decline in mortality from 1993-2017.

Unnecessary Biopsy and Treatment: Concerns of Note

Prostate cancer is a common diagnosis; 1 in 9 men will be diagnosed with it during their lifetime, usually after an elevated PSA or abnormal rectal exam. While PSAs are important, three concerns are worth noting:

1. Because PSA is only 50% accurate in identifying who has prostate cancer, many “normal patients” also undergo a biopsy to confirm results. An estimated 60-70% of all prostate biopsies return a benign diagnosis, not only causing unwarranted fear, but also billions of dollars in needless healthcare costs.
2. Most men who have prostate cancer survive; 1 in 41 die from it. The majority will be diagnosed with very low-risk or low-risk prostate cancer that does not metastasize or directly cause death. This is the current situation for 2 million men nationwide.
3. Unfortunately, a large proportion of these very-low-risk and low-risk patients have been treated with surgery, radiation and potentially harmful hormonal treatments and are suffering from side effects that deteriorate quality of life. These range from urinary incontinence and erectile dysfunction to metabolic syndrome, cardiovascular mortality and dementia.

More Advanced Diagnostic Solutions

Such concerns have raised two important questions:

1. Can we avoid unnecessary prostate biopsy and diagnosis of low-risk prostate cancer?
2. Can we identify patients who have prostate cancer but will not die from it, and thus avoid potentially harmful treatment in these patients?

The answer to both questions is a resounding, YES! This is due to more than 20 years of research in active surveillance, hereditary mutations and tremendous advances in technology, genomics and diagnostic techniques. Examples range from multiparametric MRI and fusion biopsy to free PSA, select MDx, 4k score, genomic assessment of cancer and germ line mutations.

Armed with modern technologies, urologists can provide highly precise and individualized diagnostic and treatment advice to their patients. They can also more accurately identify who should be biopsied, who can safely avoid it, and who should be treated or monitored.

Key benefits include:

1. Avoiding the side effects of prostate biopsy (e.g., infections, sepsis, erectile dysfunction).
2. Reducing unnecessary, psychologically-driven treatments based on fear.
3. Averting needless and sometimes wasteful healthcare expenditures.

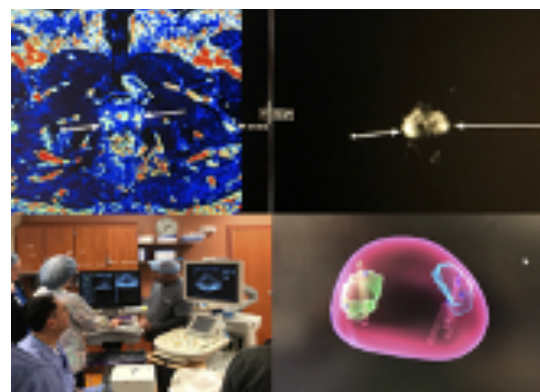
Treating Based on Risk

Once patients are diagnosed with prostate cancer, they are categorized into one of the following risk categories to personalize their treatment:

- **Very-low-risk and low-risk prostate cancer** patients can be safely monitored while avoiding treatments such as surgery and radiation.
- **Intermediate-risk** patients can be further categorized by genomics into those who can be monitored (favorable) and those who need treatment (unfavorable).
- **High-risk** patients will be started on a tailored treatment plan.

As a result, only the unfavorable intermediate-risk and high-risk patients who are at the greatest risk for metastasis and mortality are treated. Using newer molecular techniques, urologists can also customize the intensity of treatment. This approach offers the greatest probability of cure while avoiding the side effects of multimodality and unnecessary treatment.

For more information, contact Dr. Kaul at 989.583.5370 (sanjeevkumar.kaul@chs-mi.com).



- **Top left/right:** Multiparametric MRI images showing areas suspicious for prostate cancer.
- **Bottom left:** Targeted biopsy of the suspicious area; procedure performed with fusion technology.
- **Bottom right:** 3D confirmation that the biopsy has actually targeted the areas selected for biopsy.

According to the American Cancer Society, 2020 may see an estimated 192,000 new diagnoses of prostate cancer, up 8.5% from 2019 which was a 6% increase from 2018. Deaths in 2020 are estimated at 33,330, up 5.4% from 2019 which was a 7% increase from 2018. These increases may reflect a combination of improved screening and an aging population.



Stopping the Spread of COVID-19: What We Now Know

Dr. M. Umar Khan, Chief of Internal Medicine, Covenant HealthCare; Infectious Diseases, CMU

When COVID-19 started making headlines around the world, it became clear that this novel coronavirus was a deadly opponent. A short incubation period coupled with high contagion, resistance to known treatments and proclivity for people with underlying conditions caused it to spread quickly.

Since then, experts have learned a great deal about COVID-19 that can slow the spread and more effectively treat those needing additional care. This knowledge is also bringing us closer to a vaccine. Below is an update on where we stand, what to do and what to expect.

Symptoms

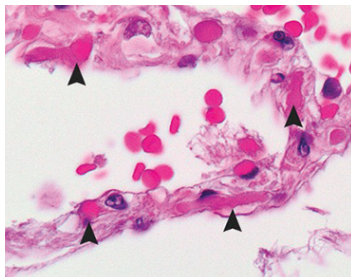
Early recognition, testing and isolation are key to stopping the spread of COVID-19. Sick patients will likely have these symptoms within 2-14 days of exposure:

- **Most common:** Fever, dry cough, fatigue, sputum, shortness of breath
- **Less common:** Myalgia/arthralgia, sore throat, headaches, chills, body aches/pains
- **Rare:** Nausea/vomiting, nasal congestion, diarrhea, hemoptysis, conjunctival congestion, runny nose

Lungs / Inflammatory Markers

COVID-19 rapidly invades lung cells in the early days of the infection, which can lead to complications requiring respiratory and other interventions. As shown below, it causes widespread inflammation that blocks airways. Key markers include:

- High ferritin
- High LDH
- High fibrinogen, PT/INR and d-dimers
- Decreased lymphocytes
- Increased basophils



The interalveolar septum of this patient shows slightly expanded alveolar walls with multiple fibrinous microthrombi (arrowheads) in the alveolar capillaries. Extravasated erythrocytes and a loose network of fibrin are seen in the intra-alveolar space (hematoxylin-eosin staining; scale bar corresponds to 50 μ m).

Prevention and Control

COVID-19 is easily transmitted human-to-human:

- **Primarily via larger respiratory droplets** or other secretions from infected people or asymptomatic carriers, especially when standing within six feet of that person.
- **Via aerosolized particles** through breathing, talking, sneezing and coughing, which can survive in the air for three hours.
- **When touching a contaminated surface**, then touching the mouth, nose or eyes – although less risky.

Avoiding crowds, social distancing and wearing personal protective equipment (PPE) like masks and glasses are proven

to reduce exposure, as are hand sanitizers, handwashing and antibacterial wipes. In the healthcare setting, goggles, face shields, gloves and gowns should also be used.

Testing, Treatments and Isolation

Suspected COVID-19 patients should be tested for common respiratory viruses first. If negative, the CDC recommends:

- Testing the upper respiratory tract with nasopharyngeal (NP) swabs, especially in higher-risk patients who are older than 65, have comorbid conditions and/or are immunocompromised.
- Testing lower respiratory specimens if available and sputum from productive coughs.

Isolate positive cases until the patient remains free of fever (without Tylenol®), cough and shortness of breath for 72 hours, with two negative NP-swab PCR tests collected 24 hours apart.

For hospitalized patients, these treatments may help:

- Remdesivir shows a mortality benefit of 3% and a reduced hospital stay of four days. Anyone requiring oxygen therapy or intubation also should be started on the steroid, dexamethasone (6 mg, once daily for 10 days).
- Tocilizumab can show positive results after a first dose, after which a second dose is given.
- For management of acute respiratory distress syndrome, better results are observed with prone positioning, oxygen, non-invasive ventilation, pulmonary vasodilation with inhalational nitric oxide, methylprednisolone IV and extracorporeal membrane oxygenation.

Immunity and Vaccines

It is still unclear whether COVID-19 antibodies (including from convalescent plasma) provide immunity, slow infection or stop reinfection.

Herd immunity is the ultimate goal, but 70% of the population must be immune for it to be effective against COVID-19. However, this needs to happen over time, so as not to overwhelm hospitals and increase death rates.

Restrictions (e.g., social distancing and masking) have significantly slowed the infection rate and should continue at some level to avoid another major outbreak. This gives researchers the necessary interlude to accelerate a vaccine – of which three are in Phase 3 trials in the U.S. and many more worldwide. That said, we will likely not see a vaccine until 2021 at the earliest.

Taking Action

Identifying cases faster is key to stopping the spread of COVID-19. Early testing and isolation, along with precautions to limit exposure, are equally critical. So is advocating for future pandemic funding and preparedness. COVID-19 reminds us all that another pandemic – and its devastating impact on humanity and the economy – could be right around the corner.

For more information, contact Dr. Khan at 989.791.7900 (mukhan1@hotmail.com).



Making Personalized Cancer Care a Priority ... and Why Testing Is Essential

Dr. Binu Malhotra, Oncology, Covenant Medical Group

Personalized cancer care has always been a goal for oncologists and patients. Historically, well-defined treatment recommendations were created for different cancers based on the organ of origin, cell type and stage, the age of the patient and more.

A huge turning point in personalized cancer care occurred earlier this century with the use of Imatinib, the first signal transduction inhibitor in a clinical setting for chronic myeloid leukemia. It prevents a BCR-ABL protein from exerting its role in the oncogenic pathway by inhibiting the constitutive tyrosine kinase activity.

A Significant Leap Forward

Such treatment advances signal a significant leap forward in personalized cancer care, thanks in part to the:

- Introduction of sophisticated analytical, testing and diagnostic techniques which reveal a wealth of information that can dramatically improve patient outcomes.
- Greater insights into cancer biology, patient history (e.g., lifestyle, genetics) and integrated, global databases of collective knowledge.

Consequently, we have a much better understanding of the behaviors of various cancers. This includes how they thrive, what treatments they respond to and what patients are more likely to respond based on their genetic predispositions, tumor molecular profiles and/or previous treatment history.

For example:

- Tumors are now known to be molecularly diverse and to behave differently in different individuals.
- Rapid DNA sequencing, analysis of the RNA, and immunohistochemistry are some of the commonly utilized testing modalities to assess for genomic alterations and the potential therapies that target the abnormalities.
- Heritable or somatic genomic alterations such as the BRCA mutation can also inform treatment recommendations in ovarian, breast and pancreatic cancers.

Patient Benefits and Success Factors

Personalized cancer care brings tremendous benefits to the patient. More targeted treatments enable higher response rates that are more robust and durable, extending lives. Patients also experience less toxicity and fewer side effects, thus improving quality of life.

Success depends on several factors, including:

- **Speed of physician response.** As soon as there is a suspicion of cancer from imaging studies or a biopsy, the attending physician should immediately bring an oncologist onto the care team. This is because imaging studies, choice of biopsy sites and follow-up testing (types and protocols) are sophisticated and evolve. Early engagement ensures more timely care and better patient outcomes.



- **Imperative of testing.** Mere identification and histologic classification of cancers is no longer enough to initiate treatment. Testing at the molecular level is imperative. For example:
 - If you suspect breast cancer, the diagnosis is incomplete if we do not have the ER, PR and HER2 status to guide treatment.
 - For stage IV lung cancer, it is vital to have the EGFR mutation, ALK translocation and PD-L1 expression tests, to name a few.
 - For stage IV colon cancer, microsatellite instability testing can change the entire course of treatment — from chemotherapy to immunotherapy.
- **Quality of core biopsies.** Different biopsy techniques are used for different cancers to gather information about the tumor. Enough tumor material must be collected to run the necessary genetic tests and assays. This is critical to understanding the specific type/subset of cancer and for developing an effective and individualized treatment plan.

Going Forward

Personalized cancer therapy is a process that begins with the suspicion of cancer and proceeds to its characterization, diagnosis, treatment and follow-up. Having the right information about the tumor and patient, as early as possible, can change treatment recommendations, prognosis and survival.

Primary care physicians, physician assistants and nurse practitioners are often at the front lines. Please remember to flag suspicious cancers as a top priority, explain to patients the urgency of further testing, and connect them with an oncologic specialist immediately.

For more information, contact Dr. Malhotra at 989.583.5060 (bmalhotra@chs-mi.net).



Insights About COVID-19 and Gastrointestinal Health

Dr. Mark Raphael, Gastroenterology, Covenant Medical Group

As COVID-19 clinical experiences worldwide reveal more insights about the symptoms and impact of this disease, an update about gastrointestinal (GI) complications – one of the lesser known symptoms – is appropriate. While GI problems are less likely to present as COVID-19 compared to a fever, cough or fatigue, they may appear as primary symptoms that carry a higher viral burden, and may thus be underdiagnosed. Below are a few important updates on this topic, in addition to information about the safe resumption of endoscopic procedures.

Is It the Stomach Flu or COVID-19?

According to the American Gastroenterological Association (AGA) and its analysis of studies from Wuhan, China, as of June 2020, gastrointestinal (GI) symptoms affect about one in four hospitalized patients afflicted with COVID-19. These include diarrhea (18%), nausea (8%), vomiting (6%) and abdominal pain (2%).

GI symptoms correlated significantly with worsened anemia and higher levels of C-reactive protein and ALT, along with worsened fatigue, sore throat and dizziness. This could suggest a stronger dehydration component to the illness. The study also revealed these symptoms were more prominent in the highly susceptible elderly population.

Although a smaller subset, patients presenting with primary GI symptoms could suggest that it may be pertinent for physicians to be vigilant about viral prodromes to increase detection and improve clinical success in those with atypical extrapulmonary symptoms. It may also help catch undiagnosed cases disguised as the flu sooner.

GI symptom-only patients were diagnosed with COVID-19 up to five days later than typical patients, and took seven to nine days longer to achieve viral clearance after stool RNA was tested by reverse transcriptase PCR, according to a study reported in the American Journal of Gastroenterology. Although data is unclear at this time, these symptoms may be due to a higher viral burden, increased bowel wall permeability, diminished barrier function and nutrient malabsorption.

The testing protocols reported in Dr. Khan's "Stopping the Spread of COVID-19" article (page 4) should be followed to confirm all cases of COVID-19. Additional abdominal CT where relevant, however, may reveal bowel wall abnormalities such as wall thickening or pneumatosis intestinalis, possibly related to microthrombi from the hypercoagulable nature of the disease state. It can also reveal other, non-COVID-19 issues that need attention.

Stool RNA reverse transcriptase PCR testing (noted above) is also an option and recommended by the American College of Gastroenterology (ACG) where available and feasible, especially in those with digestive symptoms. Note that there have been rare case reports from the ACG about presentations of acute hepatitis and hemorrhagic colitis that carry a high mortality; it is uncertain as to whether these are related to COVID-19.

Meanwhile, supportive care includes IV fluid hydration for severe weakness and renal insufficiency, IV antiemetics and medical therapy. Patients who are suspected to have COVID-19 should also self-quarantine per CDC guidelines and be treated accordingly.

Are Endoscopies Safe To Resume?

Yes, it is now safe to resume endoscopies with safe practices based on current CDC, State of Michigan and Covenant HealthCare guidelines, along with joint guidance from the AGA and the Digestive Health Physicians Association. Safe practices include social distancing and the use of personal protective equipment (PPE).

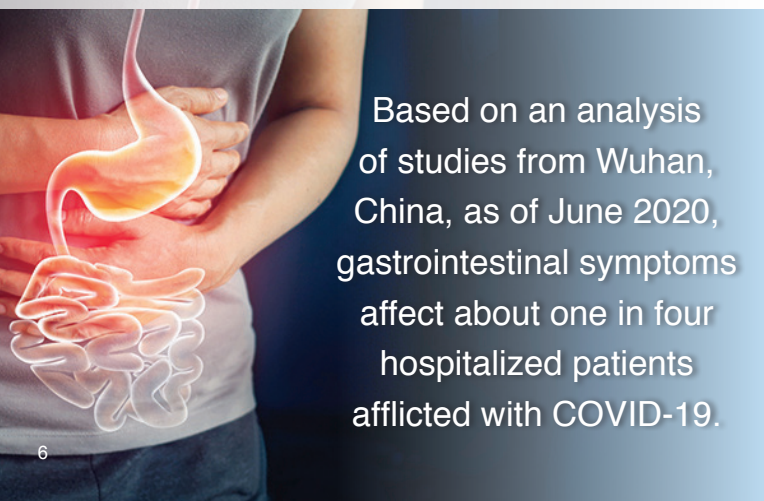
During COVID-19, only life-threatening or emergent procedures related to patient care – including but not limited to dysphagia, working-cancer diagnoses and gastrointestinal bleeding – were permitted. With the "re-opening" of Michigan to a greater degree due to the flattening of the COVID-19 curve state-wide and locally, certain elective procedures have been resumed.

This milestone is critical, partly because COVID-19 may have caused patients to delay important medical care. If patients have conditions that are affecting their quality of life or are now due for elective cancer screening exams, it appears safe to resume under the guidelines stated above.

Summary

COVID-19 is an insidious disease that presents in many ways, and we should all take care to not only assess common symptoms, but also the lesser-known symptoms such as GI issues. Diagnoses related to GI distress that reveal the presence of COVID-19 can truly help stop the spread of this disease from unknowing patients. Other diagnoses may reveal another underlying cause requiring medical intervention.

For more information, contact Dr. Raphael at 989.583.7460 (mark.raaphael@chs-mi.com).



Based on an analysis of studies from Wuhan, China, as of June 2020, gastrointestinal symptoms affect about one in four hospitalized patients afflicted with COVID-19.



Returning to a New Normal with Surgical Procedures

Dr. Todd Richardson, General Surgery, Covenant Medical Group

As the COVID-19 pandemic escalated earlier this year, so did concerns about how to manage patients when demands for personal protective equipment (PPE), ventilators and ICU beds were climbing – yet supplies were disappearing.

In response, Covenant HealthCare formed several Incident Command subcommittees in early March, including Surgical & Procedural Evaluation (S&PE). This team, which includes representatives from across Covenant, is focused on prioritizing surgical procedures while maintaining the health and safety of patients, staff, providers and the community. Effective March 17, S&PE postponed elective procedures for 30 days based on recommendations from the CDC Surgeon General and American College of Surgeons. This pre-empted Executive Orders from the State of Michigan on March 21 that temporarily restricted non-essential medical and dental procedures.

Screenings and Safety

The S&PE team met daily (later weekly) to screen cases across service lines based on a set of criteria to either proceed with urgent/emergent cases or safely delay. It also discussed all aspects of safety, including PPE, staffing, challenges, ICU and vent availability, disinfection, testing and more.

Teamwork and flexibility flourished in an evolving landscape that included the new COVID-19 hotline, testing tent, cleaning protocols, visitor restrictions and more. In Cooper, the surgical pre-operative area was converted to a clean ICU as COVID-19 numbers at Covenant grew and later, so was Endoscopy as a back-up. Staff from impacted areas were redeployed to assist wherever possible.

A Phased Roadmap to Recovery

In response to significant concerns about growing backlogs, S&PE created a phased approach to resuming operations. Considerations included case order/priority, testing abilities, resources, staffing, flow, PPE and local pandemic status.

Phase 1

Starting May 11, in addition to urgent/emergent, oncology and infection cases, this phase included general, gynecological, vascular, neuro, and orthopaedic outpatient cases which were time-sensitive and impacted patient health. Existing allocated blocks of time were replaced accordingly.

Patients were screened with Pre-Admission Testing and a COVID-19 screening process that included an algorithm aligned to CDC recommendations. For all patients, two questions were asked multiple times prior to the day of surgery:

- Do you have any new onset of shortness of breath, cough, sore throat, fever (>100.0° F), chills, body aches or muscle pain, headache, or loss of smell or taste?

- Have you had prolonged close contact (within six feet) with someone with positive COVID-19 without wearing personal protective equipment (e.g., a mask).

S&PE identified procedures that could be safely accommodated in the Harrison Operating Rooms, gathering input from all disciplines, including Pharmacy, Radiology, Biomed, Security and Infection Prevention. Surgical patients presented to Harrison Operating Rooms and were admitted to Third Floor Ambulatory. A limited number of cases were performed in the Cooper Operating Rooms to minimize traffic and exposure risk.

Phase 2

Starting May 26, this phase introduced the final essential outpatient cases in the remaining specialties, including ENT, oral maxillofacial, general pediatrics, non-cosmetic plastic surgeries, podiatry and ophthalmology. The consolidated ambulatory unit was maintained, however cases were realigned with the appropriate campus and the pre- and post-operative areas were opened at both Cooper and Harrison. Case volumes remained lower than usual, and surgeons and offices prioritized cases postponed due to COVID-19.

Phase 3

S&PE originally planned to restart non-essential medical procedures as phase 3 on June 8. Thanks to Michigan's ability to flatten the COVID-19 curve, the State rescinded Executive Orders to postpone non-essential medical procedures effective May 29. Meanwhile, Covenant was also seeing the positive impact of many safety measures, from sanitation stations at all entrances to mandatory masking, social distancing, health screenings and disinfecting protocols. After re-evaluating the situation, the S&PE team agreed to move up phase 3 to June 1.

The New Normal

Healthcare has forever changed in the wake of COVID-19. Absent a vaccine or magic-bullet treatment, many patients are worried about the health, safety and timing of their procedures and are uncomfortable with visitation restrictions. Going forward, continued collaboration and communication with patients and the community are key. Helping patients navigate their health needs while ensuring safe, quality, compassionate care is a top priority as Covenant resumes services and provides extraordinary care to all those we serve.

For more information, contact Dr. Richardson at 989.583.4674 (todd.richardson@chs-mi.com).

The Covenant Chart is published four times a year. Send submissions to:
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The Chart Spotlights

Congratulations Physicians of the Month!

Your patients and colleagues are saying extraordinary things...

JULY
Dr. Omer Mirza
CRITICAL CARE



"Dr. Mirza consistently stepped up in clinical and operational leadership during COVID-19. He provided guidance to our Covenant HealthCare team, patients and families during a constantly evolving situation while also providing care to some of our most critically ill patients. Outstanding!"

"Dr. Mirza has worked tirelessly as our ICU leader for COVID-19. He updates families regularly and helped to keep our staff safe with proper PPE guidelines. Through it all, he continued to educate our nurses through uncharted waters."

AUGUST
Dr. Amjad Nader
CRITICAL CARE

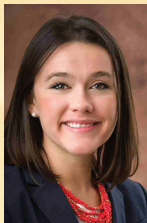


"Dr. Nader navigated a chaotic time with a steady mind, hand and demeanor. He has such grace while providing remarkable clinical care to our patients and families. Literally, excellence!"

"He is calm in an emergency; professional while remaining a part of our ICU team; CARES about his patients; and is always willing to go above and beyond. He is the physician you want caring for your family. He has gone above and beyond for Covenant HealthCare during the pandemic."

"Dr. Nader has been instrumental in caring for most of our COVID-19 patients. He seems to always be here, barely taking time off during COVID-19. He is a great physician and very compassionate."

SEPTEMBER
Dr. Barbie Fernelius
EMERGENCY MEDICINE



"The doctor was AMAZING! She was kind and very informative. All COVID-19 precautions were taken."

"I had a very good experience in the ER. The doctor who reset my shoulder was an excellent doctor. She was very thorough and courteous."

"This doctor was very concerned and helpful."