THE COVENANT Chart

Covenant HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | JUNE 2020

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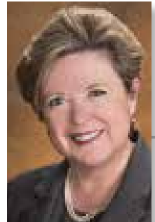


Changing Our Culture: *Touching With the Heart*

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

As I write this letter, the COVID-19 pandemic is exploding across the United States and around the world. The phrase "It's a small world" has never seemed more accurate than now. We can no longer just ask questions about foreign travel to high-risk areas like we started doing with the Ebola outbreak in 2014. What is even more frightening about COVID-19 is that individuals can be asymptomatic and contagious.

Now we need to practice social distancing which has completely shifted how we interact with each other when we come together. The six-foot distance is causing us to change many things, even our ways of greeting each other. Initially we thought we could still give an 'elbow bump' in lieu of a good handshake, but now, even that is considered too risky.

Is our changing core of interactivity behaviors going to affect our humanity? As physicians, our "touch" is part of our healing energy. I have been privileged for over 25 years of practice to have thousands of "touches" – many therapeutic but most simply from compassion, and often not just with the patients, but with their families too.

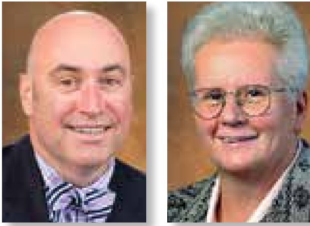
The hand on a loved one's shoulder when I deliver bad news has always been the most important aspect of delivering superlative care. I have always tried to do it with the most devoted attention to timing and duration while simultaneously delivering the verbal message. This entire moment will be embedded in a memory that this person will carry forever, so it must capture the right balance of compassion, experience and wisdom. These moments are precious to me. When I think about the eventual idea of retiring from practice, it is this connectedness to my patients and their loved ones that I will miss the most.

What can we do as we face the changes thrust upon us by a sneaky virus? I am not sure if we will ever go back to shaking hands, and I am okay if we don't. However, I do believe that we need to continue to find ways to connect with each other as well as our patients. We all need each other more now than ever before.

So, please join me as we change how we connect without losing the human element. Please be safe, be sincere, be present in the moment and don't stop touching with your heart. Be proud of what you do: you are a healer and you are extraordinary.

Thank you and Namaste,

Kathleen Cowling



Congrats, Team! We Are Beating Benchmarks for Infection Rates

But Our Work Is Never Done

Dr. Michael Sullivan, Chief Medical Officer, Covenant HealthCare, and
BJ Helton, Manager of Patient Safety and Quality, Covenant HealthCare

A hospital's ability to deliver quality patient care hinges on the power to stop the spread of hospital-acquired infections (HAIs) that put susceptible patients at risk. While COVID-19 has received significant attention lately, a variety of bacterial and fungi infections – from MRSA and C.Diff to the norovirus and influenza – can easily spread and cause death unless extreme caution is exercised.

To reduce the HAI threat to patient safety, hospitals nationwide – including Covenant HealthCare – have been implementing strict infection control protocols. A few key strategies include:

- Compliance with the Healthcare Facilities Accreditation Program (HFAP) which has increased the number of infection-prevention standards.
- Transparent communications across disciplines and the patient-centric continuum to increase awareness among healthcare workers, patients, families and communities.
- Reducing antibiotic use to minimize resistance except when absolutely needed.

Keys to Covenant Success

In addition to the protocols identified above, evidence-based protocols at Covenant are enabling it to reduce infection rates to levels that outperform the industry. Covenant has, for example:

- Over the past three years (2016-2019), significantly decreased its overall infection rate by 61.2% and its SSI rate by 61.8%, as shown in Figures 1 and 2. This data also draws a direct correlation between higher hand-hygiene compliance and lower infections.
- Not only beat its own targets since 2016, but is also beating the National Healthcare Safety Network (NHSN) benchmark for SSI rates since 2013, as shown in Figure 2.

These improvements began more than a decade ago when the interdisciplinary Infection Prevention (IP) committee expanded its team to include physicians, nurses, leadership and educators. The result is a greater understanding of problems and solutions, a more empowered Covenant culture and greater compliance at every level.

A few tactics responsible for the HAI decline at Covenant include:

- Continued attention to strict handwashing protocols.
- Consistent use of CHG antiseptic wipes in pre-surgical, post-surgical and ICU environments.
- MRSA screening and treatment of patients prior to procedures.
- Nursing focus on decreasing line days and thus secondary infections; this includes daily assessment of Foley indicators and earlier removal of lines.
- Daily bleach-cleaning of isolation rooms to reduce transmission.
- Data tracking that proves the benefits of hand hygiene and thus further improves compliance.
- Holding everyone accountable, in every role, for practicing good hand hygiene.

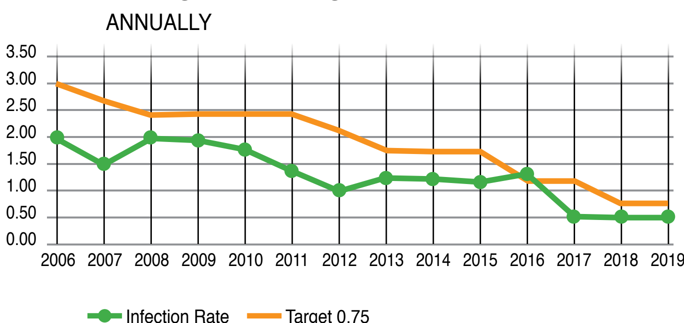
A Future Glimpse

The pièce de résistance for infection control is to never let up, especially in light of evolving pathogens and antibiotic resistance. Across healthcare, we can expect to see ongoing progress in HAI prevention and must continue to support change.

Such efforts will only heighten HAI prevention awareness and compliance. We also must hold our colleagues accountable and champion the cause every day. Together, we can continue to beat the targets and benchmarks with an extra dose of care, cleanliness and commitment.

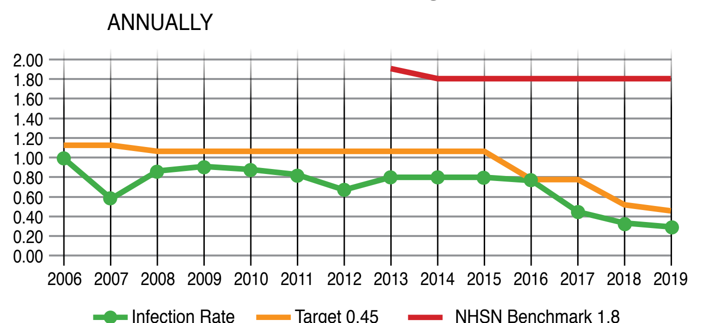
For more information, contact BJ Helton at 989.583.4257 (bhelton@chs-mi.com) or Dr. Sullivan at 989.583.7351 (msullivan@chs-mi.com).

FIGURE 1: Overall Infection Rates Decline, Beating Internal Targets*



*Notes:
Data is based on calendar year, not fiscal year.
Covenant HealthCare Targets: 2018-2020 = 0.75; 2016-17 = 1.17; 2013-15 = 1.75; 2012 = 2.13, 2008-11 = 2.43*

FIGURE 2: Overall SSI Rates Decline, Beating NHSN Benchmark and Internal Targets*



*Notes:
Data is based on 100 procedures and calendar year/quarter, calculated as a straight percentage of total procedures.
NHSN Benchmark from 2014-2019 = 1.8; 2013 = 1.9; no change in benchmark announced for 2020.
Covenant HealthCare Targets: 2020 = 0.40 (2019 = 0.45, 2018 = 0.5, 2016-2017 = 0.77, 2008-15: 1.07)*

Genetic Testing for Cancer Continues To Expand and Become More Affordable

Terese Cook, Nurse Practitioner, Covenant Medical Group Oncology

BRCA1 and BRCA2, two of the most highly penetrant breast cancer susceptibility genes, were identified in 1994 and 1995. Since then, cancer-genetics testing has expanded to include more genes, while becoming more affordable, too. Although genetic testing is not for everyone, it can be life-saving. Below are some updates that can help guide patient care.

Panel Testing Offers Tailored Plans

In 2013, "panel testing" was introduced to the cancer-fighting toolbox. Presently, over 20 genes can be screened for breast and gynecology cancers, and 80-plus genes are used routinely to assess multiple cancer syndromes at one time. For patients with a strong family history, genetic testing can help reveal potential risk factors. This offers two key benefits:

- Providers can create tailored plans for patients with a current cancer diagnosis.
- Providers and patients can make more informed decisions about cancer prevention based on current guidelines and research.

Updated Criteria for Genetic Testing

In January 2019, the National Comprehensive Cancer Network (NCCN) expanded its guidelines for *Genetic/Familial High-Risk Assessment for Breast and Ovarian Cancer* to include pancreatic cancer in the title. Previously, BRCA testing criteria had focused on a breast cancer diagnosis less than 45 years old, male breast cancer, a personal history of ovarian/fallopian tube/peritoneal cancer, Ashkenazi Jewish ancestry, and family history of ovarian and/or breast cancer.

Today, key updates include:

- The NCCN now recommends that all men and women diagnosed with exocrine pancreatic cancer receive genetic testing, as an estimated 10% of pancreatic cancers are attributed to a genetic cause. Around 2-5% of unselected cases of pancreatic adenocarcinoma will be found to have a germline BRCA 1/2 pathogenic mutation.
- Metastatic prostate cancer is also now an indication for hereditary cancer genetic testing, as BRCA2 mutations are being identified in 3-5% of patients with advanced prostate cancer.
- Testing is clinically indicated for those affected or unaffected patients with a first- or second-degree relative meeting the above-mentioned criteria.

Insurance and Cost

Coverage for genetic testing varies by insurance company. Due to a growing market for genetic testing, costs are declining. Many laboratories offer generous patient assistance programs or patient self-pay options that bypass insurance providers.

Treatment Decisions

Genetic testing can return positive, negative or with variants of uncertain significance. If a clinically significant mutation is identified, recommendations will vary based on the gene and mutation.

- Pathogenic variants in high penetrant genes are associated with higher levels of cancer risks (i.e., BRCA1 or 2). Recommendations for management are often more aggressive to include prophylactic removal of both breasts and ovaries.
- Moderate penetrant cancer genes (i.e., CHEK2 and ATM) are associated with a more moderate risk of cancer. Recommendations may include earlier detection strategies, such as frequent imaging rather than surgery.

Negative test results do not eliminate one's risk of cancer or that of family members. Nor do they rule out cancer risk associated with pathogenic variants in untested or yet-to-be-identified genes.

Screening Recommendations

Cancer screening recommendations are based on personal/family history, cancer risk calculations, and genetic test results. Patients are encouraged to check back periodically for updates on testing. If possible, it is recommended that the individual in the family most likely to carry a genetic mutation be tested (youngest age at diagnosis, multiple cancers), as it can be the most informative.

What We Can Do

Genetic testing can have a large impact on the prevention, diagnosis and treatment of cancer. Guidelines are expanding, research is ongoing, and medications to treat heritable cancers are in clinical use.

Yet, a recent population-based study published in the *Journal of Clinical Oncology* found that fewer than one-fourth of breast cancer patients and one-third of ovarian cancer patients underwent genetic testing.

We can improve upon these statistics by obtaining adequate cancer family histories and recognizing cancer clusters within families. Many facilities, including the Covenant Cancer Center, offer germline testing to help patients understand their risk and get ahead of the curve.

For more information, contact Terese Cook at 989.583.5060 (teresecook@chs-mi.com).

Hospital Medicine: *Your Partners in Patient Care*

Dr. Ganesh Kini, Section Chief and Medical Director, Hospital Medicine, Covenant Medical Group

In just over two decades since it emerged, hospital medicine has transformed the care of inpatients. Gone are the days that most primary care physicians (PCPs) round on their patients in the hospital, usually in the evening after a stressful day of appointments. Now, most PCPs are entrusting the care of their patients to hospitalists who can orchestrate care around the clock.

Today, more than 57,000 hospitalists practice in the United States, focusing specifically on caring for hospitalized patients. Understanding the role they play will help ensure the best possible care for your patients too.

A Consistent, 24/7 Resource

Most hospitalists are board-certified internists or family medicine doctors, with some receiving specialized training and certification in hospital medicine. The majority of large hospitals have a staff of hospitalists – or hospitalist contractors – who work in shifts to provide 24/7 coverage to the inpatients, 365 days per year. This adds a critical element of consistency for the patient, along with improved communications, more informed counsel, timely procedures and faster overall response.

Focused Coordination of Care

Today's medical world is constantly evolving. Between changing technologies, procedures, protocols, insurance needs and information systems, it's hard to keep up. Because hospitalists work only in the hospital, they are familiar with the changing landscape and well-positioned to lead and navigate patient care in the acute-care setting. After evaluating the patient, they consult with specialists as needed. Next, they explain the treatment plan to the patient and family, help them make decisions, and coordinate overall care from admission to discharge.

Physician Partners

Some PCPs will still make a courtesy visit to hospitalized patients to provide a familiar connection and reassurance. Either way, most rely on the hospitalist to lead the way as their "hospital partner" who manages their patient while keeping them in the loop. This saves considerable time for the PCP, and allows them to focus more of their efforts on outpatient care.

Hospitalists keep the PCP informed during their patient's stay and send a discharge summary when the patient leaves the hospital. Specific outpatient issues are also addressed in the summary, and may be conveyed in a hospitalist-to-PCP phone call as well.

Hospital Medicine at Covenant

Recognizing the growing need for hospitalists, Covenant HealthCare started the first hospitalist program in the Great Lakes Bay region with four physicians. That number has grown to more than 40 providers who have an average of 65,000 encounters per year and collaborate with nearly 200 healthcare practitioners in the region. These hospitalists:

- Act as attending physicians in the hospital environment and also provide services in the areas of co-management (acting as consultants), Code Blue coverage, Rapid Response Team support, emergency care support, and education in collaboration with CMU College of Medicine.
- Will see any patient that needs to stay in the hospital. Most come from the Emergency Care Center or are transfers from other facilities or services.
- Handle difficult situations as well, from discharges that limit driving, diet and independence to coordinating home care or hospice needs.

Summary

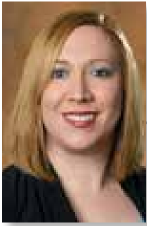
Going forward, remember that hospitalists are here to help PCPs and specialists get the right care to patients at the right time in the acute-care setting. They are uniquely prepared to offer comprehensive care to the patient, and to be at their bedside in minutes if the patient's condition changes.

As one of the fastest growing specialties in healthcare, the evidence shows that hospital medicine improves patient outcomes and provides a better work-life balance for PCPs. If you have hospitalized patients, or patients who may need admission, please take a minute to educate them about the hospitalist's role to increase their comfort level with a physician they may not know.

For more information, contact Dr. Kini at 989.583.4220 or ganesh.kini@chs-mi.com.

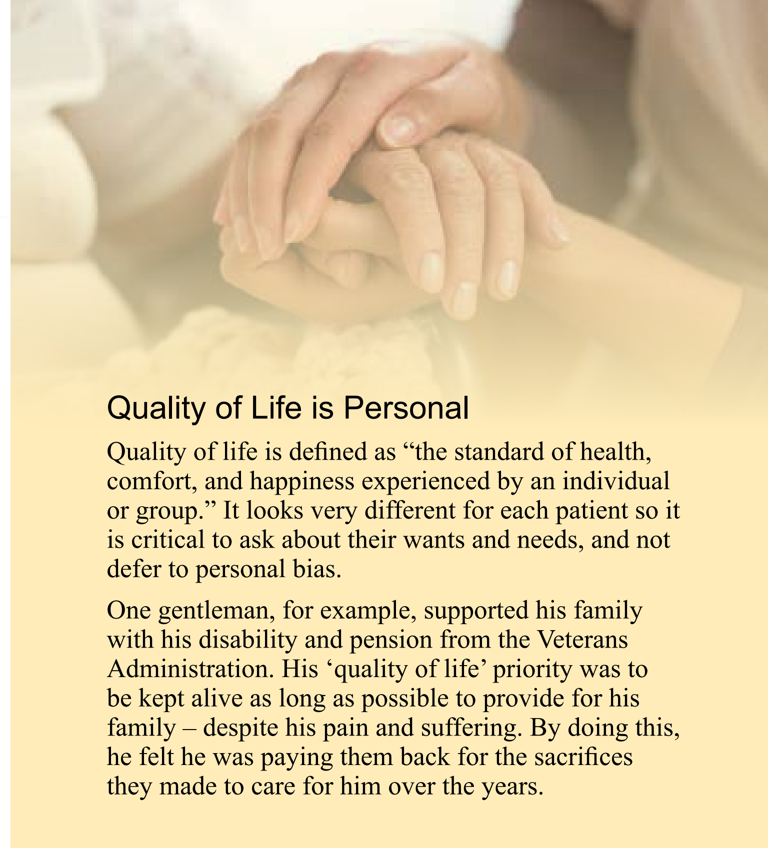
"Working closely with the Hospital Medicine Team is not only important to me as a family medicine doctor but also to my patients. When my patients know I have a way to contact their team and offer input, they feel as though they are truly the center of their care and have a voice."

– DR. TRASI CRUMRIN, FAMILY MEDICINE, COVENANT MEDICAL GROUP



How Palliative Care Eases the Burden of Serious Illness

Summer Bates, Palliative Care Nurse Practitioner,
Covenant HealthCare



Just as "it takes a village" to raise children, so does it take a village of medical professionals to care for seriously ill patients with multiple comorbidities. Palliative care is a critical tool that improves the quality of life for these patients while providing curative therapy too. Studies show that the earlier physicians integrate palliative care into the disease process, the better the patient outcomes.

Quality of Life is Personal

Quality of life is defined as "the standard of health, comfort, and happiness experienced by an individual or group." It looks very different for each patient so it is critical to ask about their wants and needs, and not defer to personal bias.

One gentleman, for example, supported his family with his disability and pension from the Veterans Administration. His 'quality of life' priority was to be kept alive as long as possible to provide for his family – despite his pain and suffering. By doing this, he felt he was paying them back for the sacrifices they made to care for him over the years.

Palliative Care Is NOT Hospice

According to the Centers for Medicare and Medicaid Services (CMS), palliative care involves "patient- and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care *throughout the continuum of illness* involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice."

Throughout the continuum of illness means that palliative care can start at any age and stage of any serious illness affecting quality of life.

Sometimes, however, palliative care is confused with hospice care and not always well-received due to the "end of life" association with hospice. The truth is that both palliative care and hospice are essential tools for managing seriously ill patients.

- **Points in Common:** Palliative care and hospice both focus on quality of life and patient-centered care, utilize interdisciplinary teams and are covered by most insurances. Neither provides 24/7 personal care.
- **Points of Difference:**
  - With palliative care, patients can receive both curative and palliative treatments for their conditions. The palliative component adds an extra layer of support for existing medical teams when it is needed most.
  - With hospice care, the attention shifts to comfort care, without aggressive, curative treatment. Hospice focuses on quality and symptom management for the remainder of a person's life.

Palliative Care Services

The goal of palliative care is to relieve pain and suffering from symptoms, and is based on patient needs not prognosis. The most common diagnoses seen by specialized palliative care teams include cancer, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease especially with dialysis, multiple sclerosis, dementia and ALS.

Palliative care is delivered in two ways:

- **Primary palliative care,** which is already practiced by many providers when they attend to the physical, functional, psychological, practical and spiritual consequences of a serious illness.
- **Specialty palliative care,** which is when further assessment and management are provided by a team of palliative care specialists who collaborate with the patient, family and other members of the patient's team to ease their burden.

Palliative care teams help guide chronic disease management by assessing the illness, listening to patient preferences and creating a tailored roadmap for treatment.

Covenant Palliative Care

The Palliative Care program at Covenant HealthCare is somewhat unique because it also covers advance care planning (ACP) in outpatient and inpatient settings. ACP helps patients and families avoid unwanted care by educating them about care options early in the process and assisting with an Advance Directive. This helps avoid confusion and difficult decisions during crisis points, while keeping the entire care team on track with the patient's wishes.

Being seriously ill isn't an easy road to travel. It truly takes a village to act in the best interests of the patient and promote a culture that accepts palliative care services. Please take the time to educate yourself about palliative care and available resources, and to promote this important service in your clinic.

For more information, contact Summer Bates at 989.583.4262 (summer.bates@chs-mi.com) or Tracy Bargeron, Program Administrator for Palliative Care and Advance Care Planning, at 989.583.6292 (tbargeron@chs-mi.com).

Vaccinating Youth Today to Prevent HPV Cancers Tomorrow

Dr. Onyinyechi Nweke, Pediatrician, Great Lakes Bay Health Centers

Every year in the United States, human papillomavirus (HPV) causes nearly 35,000 cases of cancer in men and women. Today, most of these cancers can be prevented with an HPV vaccine. However:

- Because HPV can be spread through intimate skin-to-skin contact including sexual contact, some parents feel conflicted about whether the vaccine encourages sexual activity. Per an article in the November 2012 issue of *Pediatrics*[1], getting the vaccine does not increase sexual activity.
- Because some parents did not get this vaccine, likely due to unavailability, they feel that their children don't need it.

Given this and other data, it is time to educate parents on the importance of the HPV vaccine and focus on it being the only known vaccine that can prevent HPV cancers.

HPV Overview

There are over 100 types of HPV, with most people getting at least one type of infection during their lifetime. The majority resolve spontaneously but some can cause infections that can lead to cancer:

- **High-Risk HPV** types can cause changes that are precursors to anogenital cancers. These are detected in 99% of cervical precancers and 90% of cervical cancers, suggesting a relationship between the virus and anogenital cancers (cervical, vulvar, vaginal, penial, anal and oropharyngeal). While there is screening for cervical cancer, it is not available for the other cancers caused by HPV infections. For this reason, these cancers may not be detected early before causing serious problems.
- **Low-Risk HPV** (types 6 and 11) cause condylomata acuminata or warts, recurrent respiratory papillomatosis and conjunctival papillomas.

Vaccine Overview

In 2006, the quadrivalent vaccine Gardasil® was approved for HPV types 6, 11, 16 and 18 for females ages 9 to 26 years. Together, these HPVs cause 70% of cervical cancers and 90% of genital warts. In 2009, the vaccine was approved for males of the same age span.

The earlier the age of vaccination, the better as the patient will be protected prior to sexual exposure. That said, infection with HPV is not a contraindication to vaccination as the vaccines can still protect against the types the patient has not yet been exposed to.

- The Centers for Disease Control and Prevention recommend HPV vaccination at ages 11-12, and as early as 9 for high-risk children.
- Prior to age 15, the recommended schedule is two doses, 6 to 12 months apart.
- After age 15, the schedule shifts to three doses with the first two doses one month apart, and the third dose six months later.

Vaccine Effectiveness and Safety

All HPV vaccines are highly effective and safe.

- The 4vHPV vaccine, for example, protects against genital warts and anogenital precancers, and is proven to reduce cancer risk.
- In the U.S., the prevalence of HPV infection decreased by 60% in 14- to 19-year-olds after vaccination was implemented.
- In countries with high HPV vaccination rates, genital warts decreased by up to 90%.

The most common complaints are injection site pain and swelling. The HPV vaccine is contraindicated in anyone who has anaphylaxis to any vaccine component. The 9vHPV is made with yeast and should not be given to those with yeast allergies. When vaccinating adolescents, observe them for 15 minutes seated or lying down to decrease risk of injury if they faint.

Please see the Physician Tips sidebar below for additional guidance.

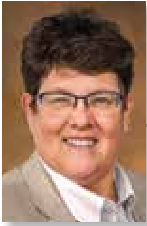
For more information, contact Dr. Nweke at 989.755.0316 (onyinye287@glbhealth.org).

[1]*Sexual Activity-Related Outcomes after HPV Vaccination of 11- to 12-Year-Olds*

Physician Tips

To help reduce HPV-related cancers, please follow these steps:

- If you see patients ages 9 to 26 in your clinic, discuss the vaccine with the parents or the adult patient, including all genders and sexual orientations.
- Explain how the vaccine not only prevents HPV infections, but is also the only known vaccine that can aid in preventing cervical, vulvar, vaginal, penal, anal and throat cancers.
- Ensure you have doses on hand for those who choose to be vaccinated; follow the recommended vaccination schedule.
- Educate yourself about HPV to increase your comfort level with the topic.
- Overcome any personal bias that may prevent you from offering the vaccine.



Specific Diagnosis of Critical Illness Myopathy/Neuropathy Improves Outcomes

Dr. Mary Margaret Snow, Physiatrist, Mary Free Bed Rehabilitation at Covenant HealthCare

Physiatrists – or physicians with Mary Free Bed Rehabilitation at Covenant HealthCare – typically see most conditions in the middle of a patient case and occasionally wish that the patient was referred to them earlier. Three examples of delayed referrals are:

- Critical illness myopathy (CIM), a motor weakness resulting from muscle damage seen in patients treated with critical illness.
- Critical illness polyneuropathy (CIP), which is less common and due to peripheral nerve damage caused by a critical illness.
- Critical illness polyneuromyopathy (CIPNM), a condition in which patients experience both myopathy and neuropathy.

Unfortunately, all are underdiagnosed despite significant morbidity and mortality. By diagnosing these conditions sooner, patients can benefit from rehabilitation and improved outcomes.

Diagnosis

Patients are typically admitted to inpatient rehabilitation after their respiratory failure is improved or resolved, and they are still in a severely weakened state. Although evaluating neuromuscular weakness can be difficult in the ICU, an electromyogram (EMG/NCS) can aid diagnosis as can detection of abnormalities in a muscle and nerve biopsy.

Clinical diagnosis includes:

- Muscle dysfunction, with the most common form being failure of myosin at the muscle fiber level.
- Profound motor weakness – proximal more than distal (extremity, trunk, neck) with comorbid factors. Bulbar muscles are spared.
- Failure to wean off ventilator support – respiratory muscle involvement.
- Elevation of CPK and aldolase may occur. In the most common type of CIM, CPK will be normal or slightly elevated.
- Risk factors of systemic inflammatory response syndrome (SIRS), sepsis, hyperglycemia and vasopressor administration. Plus females are more at risk than males. The data are mixed regarding whether the following are risk factors for CIM: renal replacement therapy, steroid use or neuromuscular blockade.

Differential diagnosis includes:

- Motor neuron diseases: ALS, polio, Guillain-Barre syndrome, vasculitis, sarcoidosis, mononeuritis multiplex or heavy metal toxicity.
- Neuromuscular junction diseases: myasthenia gravis, Lambert-Eaton myasthenic syndrome, neuromuscular blockade, botulism, organophosphate or tetrodotoxin.
- Muscle diseases: rhabdomyolysis, mitochondrial myopathy, myotonic muscular dystrophy and acid maltase deficiency or corticosteroid myopathy.

Incidence for CIM/CIP can be as high as 33% of patients treated with steroids for status asthmaticus, and as high as 70% of patients intubated for sepsis and SIRS. Furthermore, EMG/NCS testing reveals two times as many cases as appear via clinical diagnosis – another reason this condition is under diagnosed.

Recovery and Prognosis

Various studies indicate the following:

- Early mobilization and tailored physical therapy (PT) lead to shorter stays for ICU patients. While it is unclear if PT interventions lower risk specifically for CIM patients, it should help shorten rehab time.
- Intensive glucose control is recommended for these patients. Tight glucose control is the only intervention proven to decrease risk of CIM.
- Expect slower recovery for patients with CIM than for patients with physical debility.
- Prognosis is better for CIM than for CIP. In one study (in 2008), 11 out of 12 CIM patients recovered completely in six months. Conversely, CIP patients were slower to respond and more likely to have incomplete recoveries.
- Approaches that target select inflammatory cascade pathways may offer more effective pharmacological treatments in the future.
- ICU bedside care based on proven, systemic approaches may also improve outcomes.

Getting Support

If you are concerned about the potential of CIM/CIP/CIPNM in patients with a critical illness, you may want to confirm the diagnosis with a neurology or physiatry consult. A formal diagnosis, and full documentation of motor weakness, as soon as possible will not only ensure patients will receive the proper rehabilitation plan, but will also enhance their outcomes.

Additionally, early diagnosis will improve the likelihood of obtaining an insurance prior authorization from private insurance, Medicare PPO or Medicaid HMO. As of October 2019, the Medicare-allotted time for CIM patients has increased and is now more commensurate with patient needs.

For more information, contact Dr. Snow at 989.277.1650 (mmargaret.snow@chs-mi.com).

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The Chart Spotlights

Congratulations Physicians of the Month!

Your patients and colleagues are saying extraordinary things…

APRIL
Dr. Thad Rathkamp
FAMILY MEDICINE

"Visiting Dr. Rathkamp is like visiting a friend. He is very thorough and listens well."

"He is excellent, timely and professional. Fantastic care and concern are shown by the entire staff and physician."

"Dr. Rathkamp is very concerned with your health and keeps up with everything you need."

MAY
Dr. John Sharpe
GENERAL SURGERY

"Dr. Sharpe's bedside manner is great. He sat beside me, took time to really listen and never made me feel rushed. I really appreciated his sense of humor."

"Dr Sharpe is very polite, compassionate and a good listener. I believe he truly listens to understand us and makes sure we understand the answer."

"He has not only most likely saved my daughter's life, but each and every surgery he does on her he also spends time with us to explain what and why things need to be done. He is a hero in our eyes."

JUNE
Dr. Menilito Dela Cruz Lilagan
GASTROENTEROLOGY

"Dr. Lilagan and his complete staff were extraordinary, caring and talented!"

"Dr. Lilagan couldn't have been kinder. He explained everything and was very caring. He went that extra step to make me comfortable."

"Since Day One, I've had a pleasant experience with this team. This is a doctor I enjoy talking with."