THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | DECEMBER 2020

2020: A Year Like No Other

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

As we near the end of another calendar year, I'm reminded that this is usually a time for self-assessment. We ask ourselves questions like: Did we accomplish what we intended to do? Did we get derailed from our goals in life and at work? What do we want to change for the coming year?

I don't know about you, but 2020 is not a year that I would ever want to repeat due to the COVID-19 pandemic, not to mention socio-economic struggles and natural disasters. I think that we have all had enough of the "unprecedented!" We can, however, look at what we can do better for 2021 in terms of coping and responding to major events. A few ideas for consideration are below:

1. **Practice forgiveness for human frailties.** Some of us lost friends, family members and patients to COVID-19, along with the hopes of making 2020 a banner year for our practices and Covenant HealthCare. These and other stressors may have affected confidence in ourselves, others and the future. Looking ahead, we must forgive any perceived imperfections to heal and move on. No one is perfect, yet we stepped up with courage, resilience and creativity to give our patients the best, most extraordinary care we could. You should all feel proud.
2. **Use "2020 hindsight" to scrutinize 2020 as a benchmark for future decisions.** We likely will be asking "what if" questions for decades to come, such as: What if we had mandated masks before Memorial Day? What if schools had closed sooner and stayed closed? While we can easily add more scenarios to this list, we have learned an important lesson … that we can't be ostriches and stand frozen with our heads in the sand. Waiting to return to "normal" is not an option. Using the learnings of 2020, we must move forward, create a new mindset, expect the unexpected, and embrace opportunities such as telehealth that help ensure quality healthcare in an evolving landscape.
3. **Accept that change is constant; it is HOW we respond that makes a difference.** Change is difficult for most people, but we can all agree – especially now – that change is inevitable. It challenges us to step out of our comfort zone and, as they say in the world of business, "Adapt or Die." In the world of healthcare though, this adage also applies to keeping our patients alive and well. How we respond to change – with flexibility, professionalism, teamwork and swiftness – is what will define our resilience in the face of adversity.

As we take our professional and personal inventories for 2020 and ponder our New Year's resolutions, I encourage each and every one of you to include an element of forgiveness and a shot of confidence. Instead of the "what ifs," look at what we have achieved in the heat of the moment, and how we can do even better in 2021.

When it comes to challenge, they say, "The best way out is always through." Success almost always takes a team. From where I stand, the extended Covenant HealthCare team came together like never before, and it has made us an even stronger force for the future.

Best wishes to you and yours for a wonderful holiday season, and for a New Year full of hope, health and happiness.

Sincerely,

K Cowling

Dr. Kathleen Cowling

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Announcing New Clinical Trials for Breast Cancer and Metastatic Disease

Dr. James Fugazzi, Radiation Oncology, Covenant Medical Group

Phased clinical trials are a key step in identifying new treatments and diagnostics for cancer, helping the medical community understand what works, what does not and if the side effects are worth the risk. Around 1,000 potential medicines are tested for years before one makes it to clinical trials, according to the American Cancer Society (ACS).

Clinical trials for cancer should always be performed by a reputable organization that is staffed with experts across oncological disciplines and that has advanced technologies to administer treatments. A growing number of institutions are collaborating to bring qualified clinical trials closer to communities around the country.

In partnership with MD Anderson Cancer Center (MDACC), for example, Covenant HealthCare has access to hundreds of cancer clinical trials that can benefit your patients, along with targeted technologies such as BrainLab software, ExactTrac® imaging, 4D motion management and real-time image-guided systems. As an MDACC Cancer Network member, Covenant can streamline the approval process for cancer clinical trials, making them more readily available to your patients.

Two key trials being offered that could benefit patients with breast cancer or metastatic disease are OPAL (Optimizing Preventive Adjuvant Linac-based Radiation) and EXTEND (External Beam Radiation to Eliminate Nominal Metastatic Disease).

OPAL Trial

OPAL is a phase II/III study for women with early-stage invasive and non-invasive breast cancer, offering adjuvant post-lumpectomy radiation to the tumor bed only, sparing the remaining breast tissue. It is a randomized study looking at two different dosing schemes using a "hypofractionated" course of radiation, prescribing higher doses in a shorter timeframe. This protocol requires the use of implanted fiducial markers at the time of surgery (called BioZorb®) as well as daily image guidance with X-rays.

The primary endpoint is to determine subacute toxicity; secondary endpoints include the evaluation of patient-reported cosmetic outcomes, functional status and late toxicity. Additional secondary endpoints include chronic breast pain and the risk of breast cancer recurrence, disease-free survival and overall survival.

Key eligibility requirements are: woman over age 40 with stage 0, I or small (< 3 cm) stage II breast cancer that is hormone positive. Patients must have undergone breast conservation surgery (lumpectomy) with negative margins and a negative lymph node evaluation.

EXTEND Trial

EXTEND is a phase II randomized trial investigating the role of upfront local consolidative treatment in patients with limited metastatic disease (also called oligometastases). Patients are initially treated with systemic chemotherapy and then randomized to immediately receive radiation to sites of metastatic disease, or to receive no upfront radiation (the control group).

The primary endpoints are to assess the incidence of adverse events, progression-free survival, the time to the development of new distant metastasis, and overall survival. The EXTEND trial allows a few (1 to 5) extremely high doses of radiation to relatively small tumors by way of stereotactic body radiation therapy (SBRT) or stereotactic radiosurgery (SRS) to the brain.

Key eligibility requirements are: age 18 (and older), no more than five sites of metastatic disease, no previous radiation to these sites, an ECOG performance status of 0-2, adequate blood counts and no evidence of a diffuse metastatic process such as leptomeningeal disease, bone marrow involvement or carcinomatosis.

How To Participate

The ACS reports that fewer than 5% of adults diagnosed with cancer will take part in a clinical trial. This is usually because patients are uninformed or uncertain about the safety of clinical trials. They may wonder, for example, if it is better to undergo a "proven" therapy rather than one that is still being tested – even though the latter might have better, more effective treatment outcomes.

The choice is usually personal and dependent on the patient's eligibility. In any case, physicians should perform a risk-benefit review with the patient to see if it makes sense for them. If OPAL or EXTEND sound like a good option for your patients, then contact the Covenant HealthCare Radiation Center to learn more. Patients are typically seen in consultation by the radiation oncologist and their eligibility is confirmed by protocol nurses.

For more information, contact Dr. Fugazzi at 989.583.5250 or james.fugazzi@chs-mi.com.

Fighting COVID-19 Also Means Preventing Youth Suicide

Dr. Lourdes Morales-Dopico, Pediatrics, CMU Health and Erin Hanson, Pediatric Nurse Practitioner, CMU Health

The COVID-19 pandemic arrived suddenly, and children saw the closure of schools, parents glued to the 24-hour news cycle, and the abrupt loss of contact with friends and sport teammates. Healthcare providers were focused on the physical well-being of pediatric patients, and did a great job managing the first wave through telehealth and intense triage.

Now, however, the primary crisis of COVID-19 is giving way to a secondary, largely hidden mental health crisis in children and teens. As the pediatric community learned about multisystem inflammatory syndrome in children (MIS-C), it also started to see an equally dangerous threat: the surge in pediatric depression, anxiety and suicidality. Hospital admissions in general, although low for pediatric COVID-19 patients, are seeing an increase in suicide attempts and mental health-related maladies.

Awareness of Youth Challenges

Recent events and changes are just too overwhelming for children of varying ages and developmental stages to handle. Normally, the larger community offers a safety net in the form of school, sports teams, day care, play dates, after-school activities and clubs. Within a short span of time, though, the world they knew changed drastically. Now our children are interacting with teachers and classmates through a computer screen (if they have internet access), kept at home with stressed caregivers, potentially hungry with lack of school meals and, at worst, stuck without escape in abusive homes.

Children feel isolated and we are seeing the ripple effect. At CMU Pediatrics, for example, pre-school and elementary school-age patients are presenting with somatic complaints, disinterest in schoolwork, sleep disruptions, increased separation anxiety and worries about death. Tweens and teens are presenting with apathy, anger, irritability, drops in grades, non-suicidal self-injury and substance use.

Unless you ask, you will not know these feelings are emerging. Parents and caregivers might not mention it either unless, like a fever, it becomes severe.

Mental Health PPE and Screening

To prevent suicides, it is time for the healthcare community to use the right "mental health PPE" and screening, not just physical PPE, when seeing patients. This applies to any clinical setting and includes:

- Using a set of COVID-19 mental health screening questions to start a genuine conversation with children or their parents/caregivers. Even if you don't work directly with kids, you see their caregivers. A few questions to ask them include: How are things going with the family? What worries you? Are your children experiencing symptoms of depression? (Be sure to list those symptoms.)
- Being prepared with gold-standard tools like PHQ-9, GAD-7 and a Suicide Safety Plan.
- Participating in informative suicide training programs.

If there appears to be a risk, refer the patient to a local child and adolescent psychiatrist, or a community mental health agency. You can also enroll in Michigan Child Collaborative Care for additional support from child psychiatry. **See the sidebar below for key resources and links.**

Save a Young Life

As physicians, we are in a unique position to save a young life, whatever our specialty. It is critical to actively screen for psychosocial symptoms in child and adolescent patients. They may not be at highest risk for hospitalization and death from COVID-19, but they are indeed affected by the pandemic's ongoing secondary crisis of depression. By showing compassion, asking the right questions and using the right tools and resources, you could help avoid the tragedy of suicide.

For more information, contact Dr. Morales-Dopico at 989.746.7951 (moral1l@cmich.edu) or Erin Hanson at 989.746.7954 (erin.hanson@cmich.edu).

Suicide Prevention Resources

The rate of suicide among young people ages 10 to 24 increased nearly 60% between 2007 and 2018* and COVID-19 may escalate this crisis. Below are just a few resources that can help.

Patients

- National Suicide Prevention Lifeline: 1.800.273.8255
- Saginaw County Community Mental Health Authority Crisis Number: 989.792.9732
- Crisis Counselor: Text the message "Home" to 741741, then hit Send. For details, see https://www.crisistextline.org/text-us/

Physicians

- PHQ-9: https://patient.info/doctor/patient-health-questionnaire-phq-9
- GAD-7: https://adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf
- Suicide Safety Plan: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
- Michigan Child Collaborative Care: https://mc3.depressioncenter.org/
- Suicide Training Programs: www.sprc.org/training

***Centers for Disease Control and Prevention**

Impact of 21st Century Cures Act on Healthcare

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

To improve the quality and efficiency of patient care, the goal of the 21st Century Cures Act is to increase interoperability and patient access to their electronic health information (EHI).

What Does This Mean for Physicians and Hospitals?

EHI must be made available to patients on demand. The Cures Act prohibits information blocking, defined as a practice that is likely to interfere with access, exchange or use of EHI. As shown in the sidebar to the right, a range of required United States Core Data for Interoperability (USCDI) elements must be accessible to patients. While the original November deadline for compliance has been extended and is yet to be announced, **it is prudent to start preparing now.**

Because many important activities might fall into the broad definition of information blocking, the Office of the National Coordinator for Health Information Technology (ONC) made eight exceptions: Preventing Harm, Privacy, Security, Infeasibility, Health IT Performance, Content and Manner, Fees and Licensing. However, each has criteria that must be met. For example:

- **Preventing Harm** protects actions that restrict the access, exchange or use of data to prevent a qualifying patient harm or harm to another individual, when the practice is tailored to the circumstances. This exception must be made on a patient-by-patient basis and if information is withheld, it must be documented.
- **Clinical Notes and Labs/Test Results** may contain elements that a provider will deem potentially harmful to a patient or patient representative. Mechanisms within Epic will be in place to allow providers to withhold specific notes and results at the time of signing the note/order. A narrow list of sensitive results has been defined. Test orders will have an option to delay the automatic release of results for five days. Again, this determination must be made on a patient-by-patient basis and documented.

Additional Legislative Activities

Below is a summary of additional rules and regulations **with most starting January 1, 2021**.

- **Centers for Medicare and Medicaid Services (CMS) Hospital Price Transparency (CMS-17117-F2)**
  For each hospital location, hospitals must make public all their standard charges (from gross charges to discounted cash prices) for all items and services online in a single digital file and a machine-readable format.
- **Electronic Prior Authorization (ePA) and Real-Time Prescription Benefits**
  This legislation requires CMS to install regulations mandating Medicare Part D plans to accept ePA requests submitted electronically and requires that the Secretary of Health and Human Services consult with standards development organizations. The ePA workflow is designed to reduce the amount of time that patients spend waiting for their prescriptions to be released and the time that healthcare providers spend responding to calls and faxes from payers.

Required Information for Patient Access

- 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

- **E-Prescribing Controlled Substances (SUPPORT Act)**
  This mandates E-Prescribing Controlled Substances (EPCS) for all covered Medicare Part D prescriptions in section 2003, known as "Every Prescription Conveyed Securely." This sets the standard for prior authorization and requires biometric two-factor authentication.
- **CMS Interoperability and Patient Access**
  The CMS Interoperability and Patient Access final rule requires organizations to send notifications to a pre-identified primary care provider or group, or post-acute care services provider upon the patient's registration in the emergency department or admission to, discharge or transfer from the hospital.
- **Evaluation and Management Coding Changes**
  New CMS guidelines with new Current Procedural Terminology (CPT) code definitions from the American Medical Association significantly change the Physician Fee Schedule and other Medicare Part B payment policies for office and other outpatient visits, including urgent care.
- **Advance Beneficiary Notice (ABN) Form Changes**
  CMS recently published a new version of its ABN template which must be used to stay in compliance. It also provided new guidance for delivering ABNs to dually eligible beneficiaries.
- **Additional COVID-19 Policy Regulations (CMS-3401-IFC)**
  Assuring a rapid and thorough public health response to COVID-19 relies on having complete and comprehensive laboratory testing data and information. Hospitals will need to meet reporting obligations as part of Conditions of Participation. Long-term care facilities and skilled nursing facilities that do not meet weekly reporting obligations will incur penalties up to $6,500/week. CLIA*-certified labs that do not meet their daily reporting requirement will face civil monetary penalties up to $10,000/day.

**Clinical Laboratory Improvement Amendments*

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

Sacral Neuromodulation Critical to Refractory Overactive Bladder and Fecal Incontinence

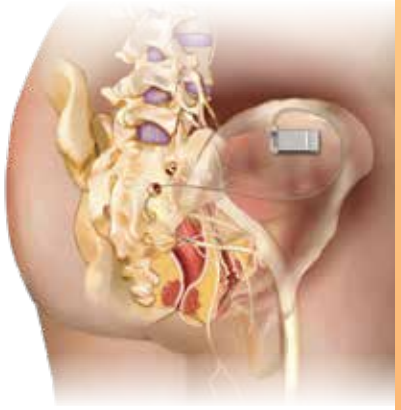
Dr. Atul Rajpurkar, Urology, Covenant Medical Group

Sacral neuromodulation (SNM) is a treatment option for the management of patients with refractory overactive bladder symptoms ranging from bothersome urgency and frequency to urge urinary incontinence, and for patients experiencing fecal incontinence. Although overactive bladder alone affects almost 50 million people in the United States, it is grossly undertreated.

When conventional treatments such as behavioral therapy and medications do not work, or are associated with side effects, SNM is a highly effective and minimally invasive treatment that is worth considering. Below are a few reasons why.

SNM Overcomes Limitations

SNM involves placing a lead wire percutaneously under fluoroscopy through the third sacral foramen against the sacral nerves which supply the muscles and organs organs contributing to bladder and bowel control. With the patient under local anesthesia, the lead wire is connected to a miniature stimulator device implanted through a small incision in the gluteal region. The electrical stimulation may eliminate or reduce the bladder or bowel problems.



Although SNM has been available for more than 20 years, many patients and physicians are still not aware of it, or are concerned about limitations such as 1) MRI incompatibility and 2) a short, three- to five-year life span of the device.

Recent FDA-approved advances in SNM technologies have overcome those imitations to allow patients to have full-body MRIs for the diagnosis of future ailments if needed. Furthermore, newer SNM devices have a life span of approximately 15 years without the need for battery replacement surgery.

SNM Benefits Most Eligible Patients

Patients who have not responded well to traditional treatments may be eligible for SNM if they are capable of operating the system, and if they pass an outpatient peripheral nerve evaluation (PNE) test performed under local anesthesia. PNE involves a 20-minute procedure in which a temporary lead is placed against the sacral nerve, after which the patient is discharged home. Next, the patient assesses the effectiveness of the test by recording their symptoms in a voiding diary for three days.

Candidates who pass the test are scheduled for the short SNM implant procedure as an outpatient. They operate the system via a small, easy-to-operate remote control, pressing a button to stimulate the organs at their discretion. The wireless implant can be charged every one to two weeks using a convenient charging belt.

The following clinical data shows that most eligible patients can benefit from SNM devices:

- In the ARTISAN SNM study using an advanced device, 89% of treated patients achieved clinically significant improvements at one year, and 93% were satisfied with the implant.
- A follow-up study at two years confirmed the durability of response in 90% of the initial responders.

What You Can Do

Start a conversation with eligible patients to see if SNM is a therapy that could reduce disruption, increase confidence and help them take back their lives. If they report issues with urgency, urgency incontinence or frequency, hope for a better future could be right around the corner. Patients who are interested should be referred to a specialist in urinary or bowel health soon for further discussion and testing.

For more information, contact Dr. Rajpurkar at 989.583.5370 or atul.rajpurkar@chs-mi.com.

DID YOU KNOW?

Urinary dysfunction is grossly under treated. In the U.S. alone, overactive bladder affects an estimated 50 million people.

The benefits of sacral neuromodulation (SNM) therapy include:

- More effective management of urinary (or bowel) incontinence
- MRI-compatible for future needs
- Long life (15 years)
- Small, inconspicuous size
- User-friendly
- Easy wireless charging
- Fast, minimally invasive procedure
- Clinically proven and FDA approved

Tips for Diagnosing and Treating Young Toe-Walking Patients

Dr. Ian Gonzales, Pediatric Physical Medicine & Rehabilitation,
Mary Free Bed Rehabilitation at Covenant HealthCare

Toe walking, or walking on the toes or ball of the foot, is pretty common and benign in children at the toddler stage. Most outgrow it but some continue to toe walk out of habit, which is known as idiopathic toe walking and could be hereditary. On the flip side, toe walking could signal an insidious process, such as cerebral palsy, myopathies, muscular dystrophy, dystonia or other congenital abnormalities. It can also be linked to sensory input issues and autism spectrum disorders.

Benign causes that are not treated properly in toddlers through adolescents can lead to contractures at the ankles, causing chronic pain issues at the ankles, knees, hips and/or back. It can also increase falls and result in social "teasing" because of the abnormal gait. Worse yet, the diagnosis and treatment of more insidious conditions could be delayed. Below are some tips to ensure good pediatric outcomes.

Diagnosis

Most toe-walking issues can be discerned through physical observation and family history. Be sure to ask parents when the toe walking started, how often it occurs, if it happens when wearing shoes and barefoot, and if it causes pain and when. In addition:

- If the child is also a picky eater, averse to certain noises or textures, avoids wearing socks and does not like people touching his or her feet, it could be a sign of sensory input issues and early signs of autism. Many autistic children cannot flex their ankles past 90 degrees.
- If there are issues surrounding the child's birth and development, proximal weakness or if the parents notice the feet are "tight" making certain activities difficult (like dressing), you may want to evaluate further for cerebral palsy or a genetic abnormality.
- If the child is having difficulties keeping up with other kids, riding a bike or going up the stairs without being fatigued, there could be an undiagnosed myopathy or muscular dystrophy issue.
- If there is a history of neurogenic bowel and bladder issues in addition to some mild/moderate gross motor delay, and if a tuft of hair or sacral dimple was found, it is likely spina bifida.

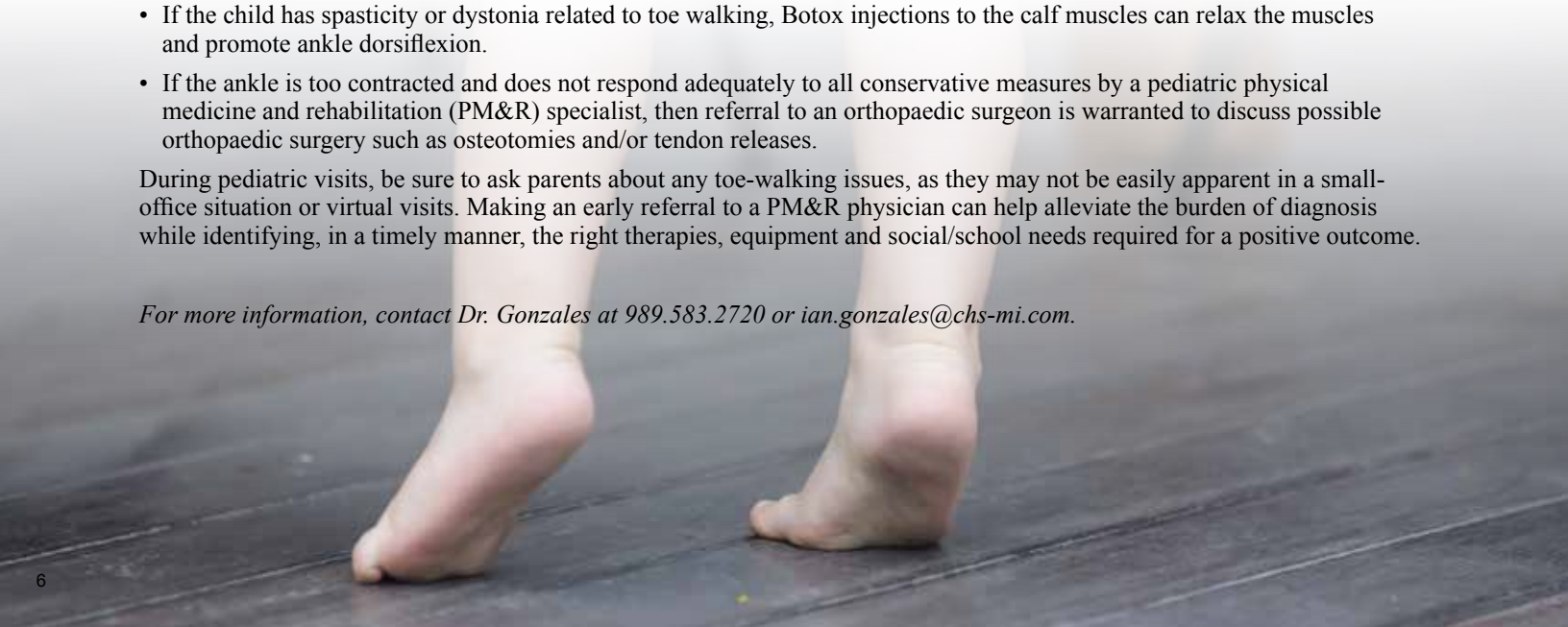
Treatments

Toe-walking treatments depend on the situation of each patient.

- For benign, mild causes such as idiopathic or sensory issues, the brain can usually be retrained by having the patient wear high-top shoes for 8-10 hours a day to promote good ankle/foot alignment. If toe walking persists while wearing shoes, ankle-foot orthotics (AFOs) may need to be worn for 4-6 months. This encourages a proper heel strike and prevents toe walking inside the shoe.
- If the child has contractures and the ankle cannot be brought to neutral, the patient may need physical therapy (PT) to improve stretching. If the contractures are severe or there is no response to PT, the child may need serial casting, a benign outpatient procedure, to improve the ankle range of motion.
- If the toe walking has an insidious cause, the patient should be referred to a neurologist or neurosurgeon immediately.
- If the child has spasticity or dystonia related to toe walking, Botox injections to the calf muscles can relax the muscles and promote ankle dorsiflexion.
- If the ankle is too contracted and does not respond adequately to all conservative measures by a pediatric physical medicine and rehabilitation (PM&R) specialist, then referral to an orthopaedic surgeon is warranted to discuss possible orthopaedic surgery such as osteotomies and/or tendon releases.

During pediatric visits, be sure to ask parents about any toe-walking issues, as they may not be easily apparent in a small-office situation or virtual visits. Making an early referral to a PM&R physician can help alleviate the burden of diagnosis while identifying, in a timely manner, the right therapies, equipment and social/school needs required for a positive outcome.

For more information, contact Dr. Gonzales at 989.583.2720 or ian.gonzales@chs-mi.com.



How To Participate In, or Initiate, a Clinical Trial

Dr. Michael Sullivan, Vice President/Chief Medical Officer, Covenant HealthCare, and
Dianne Androsuk, Central Clinical Research Department Administrator, Covenant HealthCare

Organizations at the front lines of treating disease often develop innovative ideas for new cures, treatments and technologies that are worth closer investigation. This requires intensive clinical research and eventually, clinical trials as well. It is a complex, highly regimented process to ensure efficacy, quality, and safety for the patient, and compliance with FDA requirements.

Many physicians and specialists who wish to participate in, or initiate, clinical trials don't have access to the local resources to make it happen – unless their regional hospital is equipped to manage the process and protocols. Covenant HealthCare is one such hospital and has recently made a commitment to create a strong Central Clinical Research Department that provides physicians, patients and the community with the opportunity to get involved.

Engaging in Existing Clinical Trials

The Central Clinical Research Department – which includes experienced principal investigators – is currently engaged in 35 active clinical trials in various areas of specialty such as cardiology, oncology, orthopaedics, wound care, pulmonary, gastroenterology, family medicine, radiation, women's health, urology and more.

Because Covenant is affiliated with the MD Anderson Cancer Network®, a program of MD Anderson Cancer Center, many of the oncology and radiology studies are in collaboration with this group, in addition to various pharmaceutical-generated trials (see related article on page 2).

To learn more about these existing trials, call the department to ask what is currently open for patient participation, if your patients qualify and how to get them started on this journey. See the contact information at the end of this article.

Initiating a New Clinical Trial

If you are interested in starting a clinical trial that is not currently available at Covenant, Central Clinical Research can help with that too. The Central Research Administrator and research nurses are highly experienced at managing research sites, conducting studies per protocols, and training physicians and staff to perform the study to its exacting requirements. The Administrator also works closely with doctors to identify their needs, recruit relevant clinical trial opportunities for review, and negotiate clinical trial agreements, budgets and more.

Once a clinical trial is approved to proceed, the research nurses play a major role in helping physicians lead the study, ensuring that everything meets trial protocols and FDA guidelines. This includes training physicians and qualifying patients about the protocols needed. They schedule and conduct all trial-related visits and procedures, such as IRB submissions, patient screening criteria, consents, lab draws and schedule-specific, trial-related testing (e.g., mammogram, DEXA, MRI, PFT, infusions). Research staff can also travel to physician's offices to conduct trial visits there, as needed.

Inspiring Hope for the Future

In summary, the medical advances of today owe their success to the clinical research and trials performed in the past, and the passion of doctors to make a positive difference. Bringing clinical trials closer to home – and educating patients about their availability – not only inspires hope for many patients in our community, but also builds trust and inclusion in ways that create a healthier community for the future.

For more information, call Dianne Androsuk, Central Research Administrator and Manager, at 989.583.5173 or dianne.androsuk@chs-mi.com.

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The Chart Spotlights

Congratulations Physicians of the Month!

Your patients and colleagues are saying extraordinary things…

OCTOBER
Dr. Michael Wolohan
ORTHOPAEDIC SURGERY

"Dr. Wolohan is a very well-known and respected surgeon. He has cared for members of my wife's family for years and I am honored to be a patient of his."

"Dr. Wolohan takes the time to listen. He does not rush through an appointment."

"Dr. Wolohan was very kind to my son. He answered his questions and made my son very comfortable. He has amazing bedside manners."

NOVEMBER
Dr. Jason Watha
HOSPITAL MEDICINE

"Dr. Watha was very professional. He spoke to the patient and family and answered all our questions. I am very thankful he was there for my dad and family."

"Dr. Watha took the time to help a patient be more comfortable before speaking with him. Thank you for helping us provide extraordinary care!"

"Dr. Watha did an "above and beyond the call of duty job" of trying to make me feel the care I was getting is the best."

DECEMBER
Dr. Michel Hurtubise
MEDICAL ONCOLOGY/ HEMATOLOGY

"Dr. Hurtubise is an excellent doctor – very knowledgeable, caring and an asset to Covenant. He gets an A+++ in my book."

"He is a wonderful doctor. I have been with him since 2011 and cannot say enough as to how easy he is to work with! He's knowledgeable and caring!"

"Dr. Hurtubise and his staff are always amazing!"