THE COVENANT Chart

Covenant HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | JUNE 2019

The Power of Spirituality

Dr. Sarosh Anwar
Covenant HealthCare Chief of Staff

As the power of technology drives significant advances in healthcare, the power of spirituality is getting its fair share of attention too.

Treating Body, Mind and Spirit

Treating the body, mind and spirit together is shown to boost patient health and healing, both physically and emotionally. It also supports the practice of relationship-based, compassionate care, including the tenets of "attuning, holding, wondering and following" that have been shared with staff across Covenant HealthCare. On the spiritual side, "attuning" focuses on mindfulness, respect and state of being while "holding" focuses on creating a calm, safe haven for the patient.

Being compassionate means adding the human element to medical care, so that it's not just the cold science of diagnosis, treatment and expectations that the patient hears. By connecting on the empathetic, spiritual level – whether it's holding their hand or praying with them – physicians can significantly lighten the patient's burden. This, in turn, can help:

- Relieve stress, fear and anxiety.
- Calm the patient and help them cope with their situation.
- Improve their optimism and courage to overcome their challenge.

Personal Reward

Physicians also reap the personal reward of knowing they have helped the patient feel safer and more secure, and did everything they could to heal what ails the patient – scientifically, spiritually and respectfully.

When I round on patients in the ICU, I routinely introduce myself even when they are unresponsive as a measure of respect. I ask their approval to examine them, explain my impressions and plan, and with their permission (or their family's), I ask them to pray as well. Patients do remember! One lady who followed up with me as an outpatient asked if I was the doctor who asked her to pray. She had been previously admitted to the ICU at Covenant and was on a ventilator for 10 days. She remembered my voice and that asking her to pray gave her courage.

That meant a lot to me, and made me realize that those seemingly small gestures can have a big impact, and with very little time invested. As physicians, we are chief influencers of the healing process, and would do well to remember that there are many components of care that go beyond the tubes and scalpels, entering realms of healing that we do not yet fully understand.

Useful Resources

To learn more about compassionate care and how you can make a bigger difference, I suggest that you:

- Connect with Christin Tenbusch, the patient experience administrator at Covenant, who is an expert at helping physicians deliver compassionate care.
- Attend conferences about the intersection of medicine and religion.

I personally vouch for the annual Medicine and Religion Conference, which is attended by physicians across beliefs and faiths, in addition to pastoral care experts. Here is the link: http://www.medicineandreligion.com/advisory-board.html.

These and other resources can provide a deeper understanding about how spirituality, prayer and other approaches are helping physicians around the world improve patient outcomes.

Sincerely,

Sarosh Anwar

CONTENTS

Covenant Regional Thumb Network Drives Collaboration 2
Opioids: Turning the Tide and Saving Lives 3
Breast Cancer Screening: Is it Time To Reboot? 4
REBOA: A Less-Invasive Approach To Stop Bleeding 5
Cracking Down on Concussions 6
The Impact of Epic and IT on Care 7
The Chart Spotlights – Celebrating 10 Years! 8

Covenant Regional Thumb Network Drives Collaboration

AUTHOR
Ed Bruff, President and CEO, Covenant HealthCare

To strengthen the quality and efficiency of healthcare in the Thumb Region, Covenant HealthCare and five critical access hospitals (CAHs) have created the Covenant Regional Thumb Network (CRTN). This unique network is designed to take collaboration and resource-sharing to new heights.

CRTN Members

Formed in late 2018 and announced in March, the CRTN is comprised of Covenant HealthCare and the following CAHs: Deckerville Community Hospital, Harbor Beach Community Hospital, Hills & Dales General Hospital, Marlette Regional Hospital and Scheurer Hospital (see map).

The CAHs, which already have a long history of collaborating with Covenant and each other, want to remain independent, especially after McLaren acquired Caro Community Hospital and Huron Medical Center in Bad Axe.

The CRTN is a resource to the CAHs that helps them maintain their independence, boards and leadership teams, and draw upon each other's strengths. Their connection with each other and Covenant will only get stronger through a collective, team environment of resource-sharing, network meetings and communications.

Key CRTN Benefits

Usually, when people and institutions work synergistically instead of alone, "The whole is greater than the sum of its parts," a phrase coined by Aristotle. In this sense, the benefits of the CRTN will help deliver more value than any one member could deliver alone. Examples include:

- **Member hospitals** get a more streamlined, coordinated flow of resources from Covenant – from cardiology and oncology to laboratory services – that are typically confined to larger metropolitan areas. Covenant purchasing power can also help decrease overall supply costs for members. This helps the CAHs stay viable as "safety net" hospitals in rural communities.

- **Patients** have the convenience of going to a local hospital close to home, and the security of knowing their provider can easily tap into Covenant for advanced procedures and resources when needed.
- **Communities** retain the strength of a local, independent hospital that residents can depend on for quality care and a familiar hometown touch, instead of losing it to an acquisition by an outside hospital conglomerate.
- **Covenant** can further its vision to deliver extraordinary care to every generation in rural communities too, deploying services and specialists when possible to keep care local. While not a condition of the CRTN agreement, Covenant could also see an increase in referrals from CRTN members to meet specialized needs. In this situation, Covenant specialists would treat patients as requested, then return them to the referring Thumb-based provider (e.g. primary care physician) for continued care.

Next Steps

Covenant is vested in collaborating with members of the CRTN to maximize the value the network brings to members, patients and communities. For example:

- Ongoing CRTN meetings will further strengthen the network, streamline and speed up the flow of services, and create an exciting hub of knowledge-sharing.
- Physicians can expect to hear more about opportunities to participate in, or contribute toward, CRTN initiatives. These may include serving patients and hospitals in the Thumb through satellite clinics or other mechanisms when additional medical staff expertise is needed.

Extraordinary care goes beyond medical services to serving our patients and communities better through relationships like the CRTN. Together, we will build a healthier Michigan and future for us all.

CRTN hospital member CEOs (left to right) Jean Anthony, Paul Clabuesch, Angela McConnachie, Terrance Lerash, Ed Bruff and Dan Babcock.

For more information, contact Karen Bedford, director of Physician Relations & Regional Outreach, at 989.751.6665 or karen.bedford@chs-mi.com.

Opioids: Turning the Tide and Saving Lives

GUEST AUTHORS
Dr. Matthew Deibel, Emergency Care Center Medical Director, Covenant Medical Group and
Brooke Barnhill, RN, Covenant HealthCare Opioid Committee Chair

In the past few years, news of the opioid epidemic has made national headlines, finally calling public attention to the crisis and its tableau of devastation. This has ignited national awareness, driving change on how we manage pain, overdoses and addiction. Progress is being made, but there is still a long way to go before the tide is turned.

The Hard Reality

The statistics for opioid-related deaths are always shocking. According the Centers for Disease Control and Prevention:

- Drug overdoses from opioids have dramatically increased over the last two decades, with deaths increasing nearly six-fold between 1999 and 2018, or about 218,000 people.
- In 2017, opioids killed more than 47,000 people with 36% of those involving prescription opioids. Opioid deaths continue to rise among men and women across races, ages and all walks of life.
- In 2017, Michigan physicians wrote about 74.2 opioid prescriptions per 100 people – far above the national average of 58.7 scripts per 100 people, and the state had 2,729 overdose deaths.

Clearly, the human toll of the opioid crisis is enormous, but so is the economic price, reaching $115 billion in 2017 alone per the American Medical Association. This does not include impacts such as quality of life, broken families, costs of incarceration (often coupled with drug addiction) and community health.

Taking Action

In response, more than 30 states have enacted prescription-related legislation to restrict opioid prescriptions. Furthermore, waves of investigations into corrupt drug companies (e.g. Purdue Pharma) and pain management clinics are helping to stem the flood too.

Outside the legal realm, we're seeing progress on other fronts as well, such as:

- Changes in pharmacy prescription security to reduce fraud.
- Patient record monitoring software to avoid doctor-shopping.

Saving Lives: It's Our Job

Sadly, opiate prescribing is still about three times higher than 1999 levels with many addictions beginning with the first prescription. This trend began in the 1990s when drug companies started marketing opioids like OxyContin as not being addictive, even lecturing this point to medical students.

Now we know better. To "do no harm," physicians should avoid prescribing opioids whenever possible, while helping patients who may have addiction issues. These six tips are a good place to start:

1. **Educate and empower patients to make safe choices.** Share treatment options to help patients make informed decisions. Educate them about the risk of prescription opioids, how to use and store them safely, and the risk of non-prescription opioids too.
2. **Try alternative approaches to opioids.** Explore recent advances in pain management procedures – from ultrasound therapy to joint injections. Make them your first line of treatment.
3. **Reduce the supply of prescribed narcotics.** If an opioid is necessary, write the smallest possible script (quantity and dose) for acute episodes of pain only and follow up with patients to see how they are doing. Most hospitals and clinics, including Covenant HealthCare, have strong policies in place to limit prescribing.
4. **Reduce the stigma.** Patients with addictions have big hurdles to overcome. Working compassionately with those caught in addiction can help start the healing process.
5. **Consider medication-assisted treatment (MAT) for patients who have an opiate use disorder.** MAT combines counseling, behavioral therapy and medications to relieve withdrawal symptoms and cravings. MAT patients have improved outcomes, fewer hospital stays, less criminal behavior and lower rates of overdose death.
6. **Support emergency treatments for overdose victims.** Narcan® (naxolone), for example, can reverse opioid overdose within two to three minutes. Having this on hand at schools and events (similar to automatic external defibrillators), allows for immediate treatment and is proven to save lives until emergency personnel arrive.

It took a decade for opioid use to become a crisis, and it will likely take years to resolve. Physicians can make a difference now, however, by following the tips described above.

For more information, contact Dr. Deibel at 989.583.6022 or mdeibel@chs-mi.com.

Breast Cancer Screening: Is it Time To Reboot?

GUEST AUTHOR
Dr. Joseph Contino, Breast Surgeon, Covenant Cancer Care Center

In 2009, Connecticut passed legislation requiring insurers to notify women of their breast density results and effect on mammogram screening sensitivity, and to cover breast ultrasound as an adjunctive screening test. Since then, notification laws have been passed in dozens of states, including Michigan.

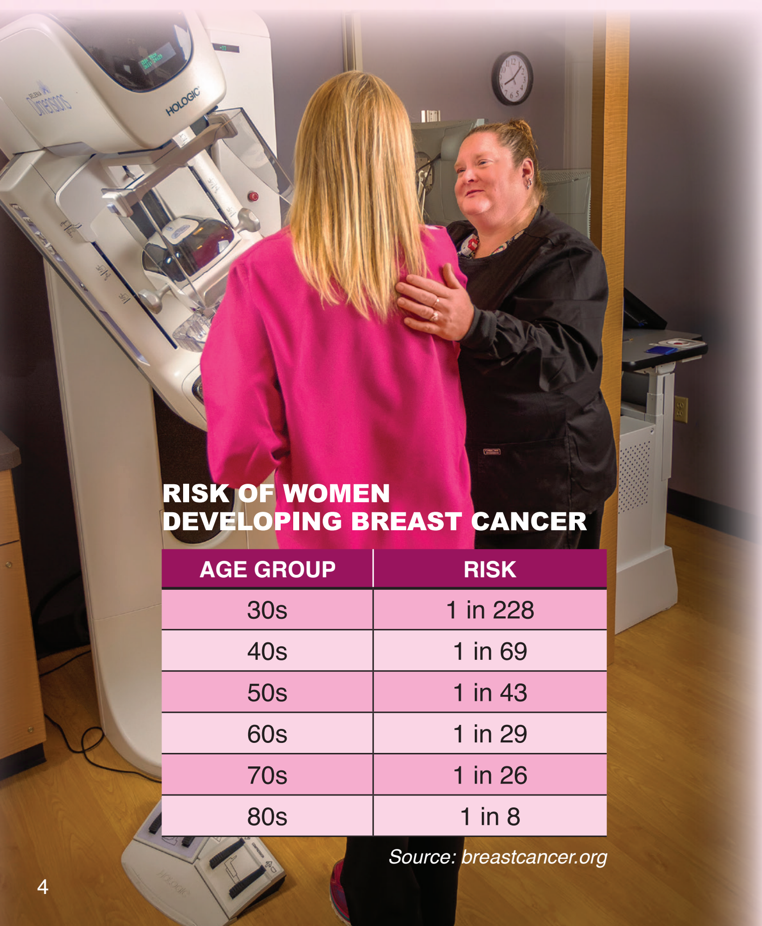
This has led to a spike in supplemental screening, including automated whole breast ultrasound (AWBUS) and magnetic resonance imaging (MRI). It is also raising the question: Are the benefits worth the potential personal harm of additional testing, negative biopsies, personal stress and unnecessary costs – especially in the absence of supporting evidence?

So what do we tell patients about screening? The information below provides some clarity.

The Value of Mammogram Screening

Fortunately, widespread screening and advanced treatments are significantly reducing breast cancer mortality. The risk increases as women age (see table below), with one in eight woman living to age 80 developing breast cancer.

In a recent *Annals of Surgical Oncology* article, it was shown that screening mammography substantially reduced treatment intensity in the 50- to 69-year-old age group that participated in the screening – underscoring the value of mammography in today's healthcare setting.



RISK OF WOMEN DEVELOPING BREAST CANCER

AGE GROUP	RISK
30s	1 in 228
40s	1 in 69
50s	1 in 43
60s	1 in 29
70s	1 in 26
80s	1 in 8

Source: breastcancer.org

The Question of Breast Density

Dense breasts are actually common in younger women, yet younger women have lower rates of breast cancer. Plus, about 85% of breast cancers occur in women with no history of this disease. One must therefore infer that a) there are complex factors for developing breast cancer that go beyond breast density, and b) perhaps additional screening is not warranted for these women.

Breast density laws:

- Do not address risk such as age, family history, genetic mutations or prior breast biopsies.
- Could give a false sense of security to women with lower breast density, causing them to avoid or delay screening.

Such concerns are reinforced in the 2015 recommendations for breast cancer screening from the United States Preventative Services Task Force which:

- Asserts that current evidence is insufficient to assess the benefits versus harms of adjunctive screening through AWBUS or MRI.
- Reinforces their 2009 recommendations that screening in women under 50 should be individualized, and that women at average risk should start at age 50 on a biannual basis.

This is further backed by a National Cancer Institute opinion stating: Recent research has suggested that a dense-breast screening strategy that also takes into account a woman's risk factors and protective factors may be the best predictor of whether a woman will develop breast cancer after a normal mammogram and before her next scheduled mammogram.

Screening – More Than Imaging

We are starting to recognize that evidence shows a breast screening plan should not be a "one size fits all" scenario. Instead, it should be individualized to the patient, involving factors like genetic testing, a clear patient history and risk-based decision making with the patient to assess benefits versus harms. Such plans are the future of breast cancer prevention, and are the target of the WISDOM study initiated in 2017 to determine better ways to screen for breast cancer.

While waiting for those results, it is time to reboot our thinking on breast cancer screening, and maybe think twice before ordering supplemental tests based on dense breasts alone. Physicians can start by initiating counseling discussions with patients about risk factors and genetics – noting that genetic testing has been expanded beyond BRCA to a 23-gene panel.

Patient portals such as breast360.org, supported by the American Society of Breast Surgeons, can also help with patient risk assessments and reduction strategies.

For more information, contact Dr. Contino at 989.395.1234 or joseph.contino@chs-mi.com.

REBOA: A Less-Invasive Approach To Stop Bleeding

GUEST AUTHOR

Dr. Sujal Patel, Trauma Medical Director, Covenant Medical Group

Noncompressible torso hemorrhage is a leading cause of early death in trauma patients. In response, trauma surgeons are increasingly using resuscitative endovascular balloon occlusion of the aorta (REBOA) to stop bleeding. This is because REBOA is a less-invasive technique with a potentially lower mortality rate than a) resuscitative aortic occlusion (RAO) which requires a left thoracotomy or laparotomy for aortic exposure or b) aortic cross-clamping (ACC).

Background

REBOA is an alternative approach to RAO and ACC in patients with rapid blood loss and the risk of imminent cardiovascular collapse. It is performed through a femoral artery approach without the need for thoracotomy (reducing surgical repairs), and is best when the site of hemorrhage is below the diaphragm and no open thoracic intervention is needed.

Indicators and candidates include:

- Hypotensive (SBP ≤90) and partial, transient or non-responders to resuscitation
- Emergency control of hemorrhage below the diaphragm
- Prophylactic use if the two indicators above are suspected
- Patients with refractory hemorrhagic shock, blunt or penetrating abdominal trauma, pelvic fractures causing pelvic hemorrhage or ruptured abdominal aortic aneurysms
- The crashing trauma patient with no obvious cardiac injury

Goals are to:

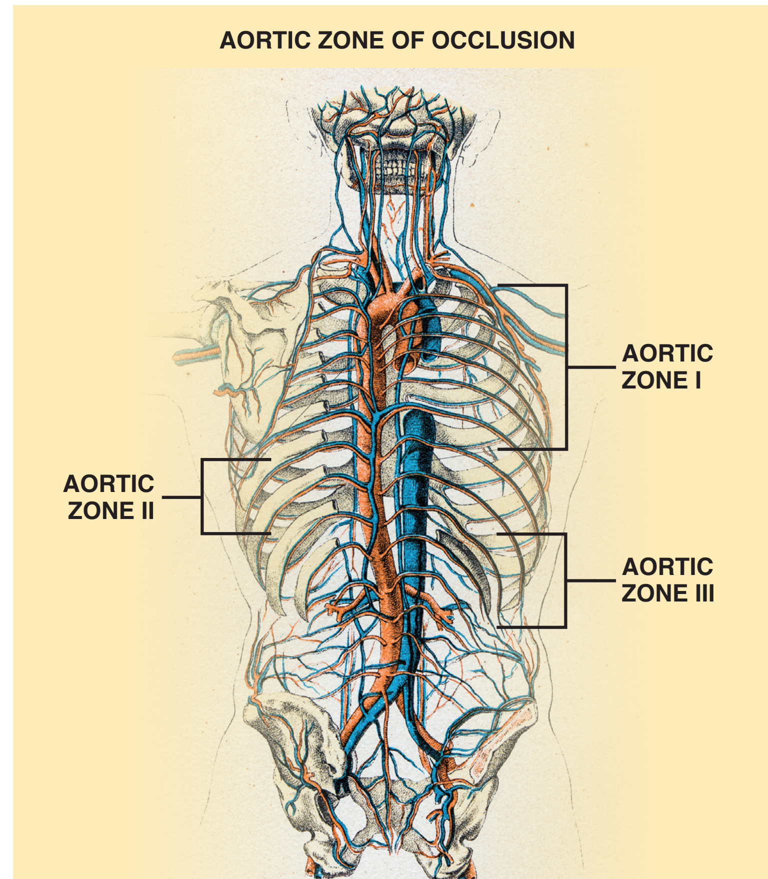
- Temporarily occlude the aorta.
- Provide temporary emergency control of hemorrhage distal to the balloon.
- Temporarily restore and monitor blood pressure proximal to the balloon.
- Improve myocardial and cerebral perfusion for patients in shock or at risk of shock.

Procedure

REBOA involves placement of an endovascular balloon in the aorta to control hemorrhage and to augment afterload in traumatic arrest and hemorrhagic shock states.

The physician passes a vascular sheath through the common femoral artery, floats a balloon catheter to the appropriate section of the aorta, and inflates the balloon to occlude blood flow. The aorta is divided into three zones (see image). Balloon occlusion is performed in Zone 1 for abdominal injuries and Zone 3 for pelvic injuries; Zone 2 is a proposed no-REBOA zone.

REBOA is typically performed in the emergency room to stabilize the patient for immediate surgery. The balloon can only be inflated for a short amount of time ranging from 30 minutes for Zone 1 to 60 minutes for Zone 3. Some research shows longer inflation times, so this could change in the future.



Training and Outcomes

As with all medical procedures, REBOA can have complications and should only be performed in trauma centers set up for REBOA management. Covenant HealthCare, for example, has a well-defined set of REBOA protocols and several surgeons trained in the procedure.

While current clinical literature regarding the effectiveness of REBOA is equivocal, REBOA has less physiologic disturbance than RAO and ACC, can be performed more quickly in skilled hands and has higher rates of technical success. Given this and ongoing studies, REBOA is becoming the standard in most higher level trauma centers for resuscitative hemorrhage control as opposed to other methods.

As more data becomes available on REBOA outcomes and management after deployment, Covenant trauma surgeons are committed to retrain themselves quarterly to maintain proficiency. Success in trauma patients has also led to success in other patients with vascular insult, such as patients with ruptured aortic aneurysms. The future of REBOA will include a multi-speciality modality to further improve patient outcomes.

For more information, contact Dr. Patel at 989.790.4855 or Sujal.Patel@chs-mi.com.

Cracking Down on Concussions

GUEST AUTHOR

Dr. Brian Purchase, Sports Medicine, Covenant Medical Group

An estimated 3.8 million concussions are reported in the U.S. per year during competitive sports and recreational activities, with most occurring in football, hockey, rugby, soccer and basketball. Physicians, patients and parents need to recognize that concussions:

- Can result from a blow to the body, not just the head.
- Are a functional not structural injury.
- Often do NOT involve loss of consciousness.
- Can be treated successfully if attended to immediately.

Key Symptoms

A sport-related concussion is a mild traumatic brain injury from forces caused by a direct blow to the head or from an impulsive force to the body that is transmitted to the head. This typically results in a rapid onset of short-lived, neurologic impairment that resolves spontaneously. Signs and symptoms may develop within minutes to hours and last days to weeks.

Because concussions are a functional disturbance versus structural injury, no abnormality is seen on standard imaging studies such as CT scan or MRI. Nor do they always involve loss of consciousness. Therefore, it is critical to pay close attention to the mental and physical symptoms shown to the right. For most teenage athletes, the symptoms resolve within a few weeks but can last for months.

Important Laws

Every state, including Michigan, now has laws related to concussion management. The laws:

- Require concussion awareness training for coaches and education for parents and athletes.
- Protect children, mandating immediate removal of the athlete from physical participation with no same-day return if a concussion is suspected.
- Require students to be cleared by an appropriate health professional, including completion of a graduated exertional protocol, before returning to play.

Details are posted on the Michigan Department of Health and Human Services website.

CONCUSSION SYMPTOMS ALERT

Physical
- Headache
- Feeling "pressure in head"
- Nausea and vomiting
- Dizziness
- Blurred vision
- Photo-phobia
- Phono-phobia
- Poor balance
- Feeling "slow"
- Feeling like "in a fog"
- Fatigue
- Drowsiness

Cognitive
- Poor concentration
- Poor memory
- Confusion

Emotional
- Sad or depressed
- More emotional
- Irritable
- Nervous/anxious

Sleep
- More than usual
- Less than usual
- Difficulty falling asleep

Current Treatment Protocol

When a concussion is suspected, sideline and office assessment tools can be used to evaluate for dizziness, memory deficits, poor concentration and visual changes. Neurocognitive tests can also be used to help make return-to-play decisions.

Experts from the Covenant Trauma Injury Prevention Program, Physical Medicine & Rehabilitation (PM&R) Department and Sports Medicine offer ImPACT testing. This computerized test measures memory, attention span and visual/verbal problem-solving. It has two primary uses:

- Before the onset of an activity, a baseline test is conducted to measure the athlete's performance at a given point in time.
- In the event of an injury, a post-injury test can be administered and compared to the baseline.

After a concussion, it is not unreasonable to restrict all activity for one to two days while monitoring symptoms closely. Athletes should then be encouraged to become more physically and mentally active while staying below their symptom exacerbation thresholds. When back to normal, the athlete must successfully complete a graduated exertional protocol before being cleared for unrestricted activity.

However, if symptoms of concussion persist or are severe, vestibular rehabilitation should be considered. Covenant PM&R has an advanced concussion program with specially trained physical therapists. Equipment like the NeruoCom®, a computerized dynamic posturography device, can help assess and retrain the sensory and motor system to improve balance.

Sharing With Parents

Physicians can help mitigate potential future cognitive issues by educating parents and athletes during annual physicals, sports physicals and other visits. Athletes should, for example:

- Be encouraged to wear proper-fitting protective gear and follow the rules of the game.
- Immediately report concussion symptoms instead of hiding them.
- Take time to recover.

Tell athletes that it's really not "cool" to stick it out, as they are only putting their future at risk. When in doubt, they should be strong and sit it out.

For more information contact Dr. Purchase at 989.583.0280 or bpurchase@chs-mi.com. You can also refer to PM&R at 989.583.6386.

The Impact of Epic and IT on Care

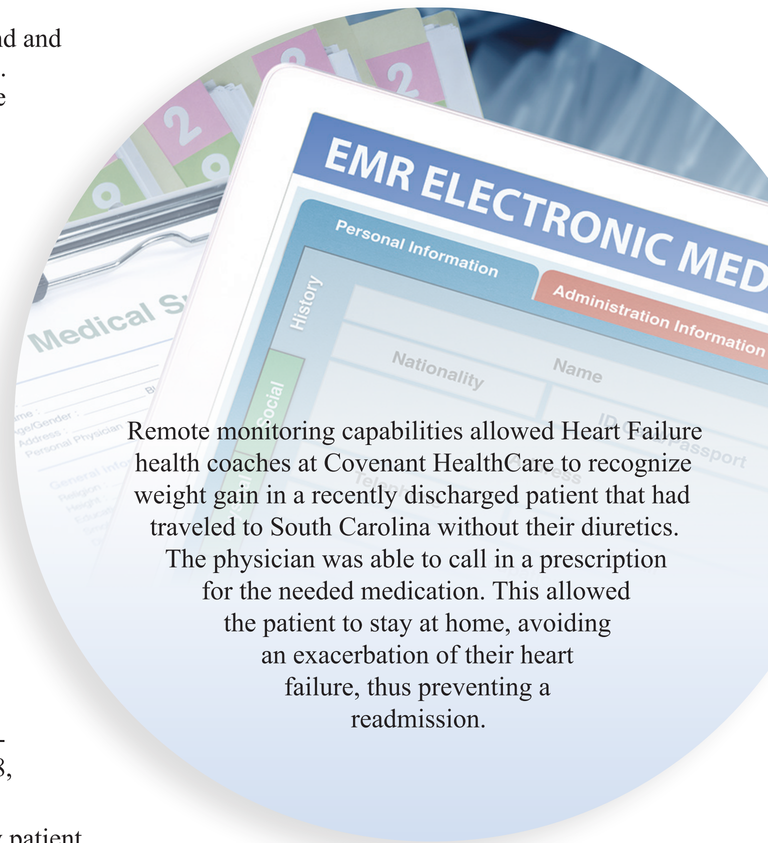
GUEST AUTHORS
Dr. Aaron Smith, Chief Medical Informatics Officer, and Frank Fear, Chief Information Officer

Information Technology (IT) tools like Epic are responsible for significant advances in healthcare quality, safety, efficiency and patient satisfaction. From patient admissions and education to treatments and surgeries, healthcare institutions require IT to deliver the best possible care to patients of all ages.

Epic, for example, helps keep patient records current, accurate and accessible to providers and patients alike. To date:

- 72% of the U.S. population has an Epic chart
- All of the "Best Hospitals, 2018" in the *U.S. News & World Report* use Epic
- 68% of Leapfrog Safety Grade A institutions use Epic

Covenant HealthCare implemented Epic in 2007 and continues to expand and update its Epic capabilities – with a new version rolled out in early June. This will allow physicians to place simple orders for inpatients using the Haiku and Canto apps on their smartphones or iPads, and to receive result alerts from lab tests on these devices. As an example, utilizing this capability, you would be able to make Ventilator setting changes and order a follow-up ABG. The results of this ABG could then be sent to your device. This functionality would also allow you to place orders and avoid verbal orders.



Remote monitoring capabilities allowed Heart Failure health coaches at Covenant HealthCare to recognize weight gain in a recently discharged patient that had traveled to South Carolina without their diuretics. The physician was able to call in a prescription for the needed medication. This allowed the patient to stay at home, avoiding an exacerbation of their heart failure, thus preventing a readmission.

Covenant also continues to implement a number of other IT tools designed to deliver extraordinary care for every generation. Embracing IT is aligned to several strategic Covenant initiatives to:

- Decrease readmissions.
- Enhance patient check-in welcome.
- Drive bar-coded medication administration.
- Utilize the Vocera communications and collaboration tool to increase response time, expanding it to nursing smart-badges, desktop applications and smart-phone apps.

Excellent progress is being made. A few cases in point are:

- The AvaSure TeleSitter® virtual monitoring initiative helps decrease patient falls and free up staffing to address other patient needs, including medicine administration. Since AvaSure was implemented in 2018, falls have been reduced by 30%.
- Remote patient-monitoring kits allow patient health coaches to follow patient vital signs and progress as they transition back to their home.
- The following Epic capabilities: Beaker Lab, Long-Term Care, Home Health and Hospice, Wound Care, Leave of Absence, EVS and Transport, and Refuel (Epic Best Practice Foundation System).
- Virtual desktops and population health analytics (e.g. Epic Healthy Planet, Dimensional Insight and Qlik)
- Barcode administration for blood and breast milk.

Covenant is committed to these and other leading-edge activities because patients deserve the very best at every turn. It is also focused on improving the provider's user experience. Several new initiatives are underway, including refined preference list options, improved note templates and personalization labs. Such improvements will help increase provider efficiency and decrease the physician's time in Epic, which in turn will help increase time with the patient.

As the face of healthcare changes, it is especially important to stay focused on IT solutions that enable Covenant to adapt to the times and that empower staff to deliver ever-better extraordinary care. Done right, this can be achieved efficiently, effectively and reliably, constantly reinforcing Covenant's position as a leader in the industry.

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

COVENANT HealthCare

Extraordinary care for every generation.

Covenant HealthCare
1447 North Harrison
Saginaw, Michigan 48602

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

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

©2019 Covenant HealthCare.
All rights reserved. PK 6/19 11676

THE CHART SPOTLIGHTS

Celebrating 10 Years!

The Covenant Chart made its debut in early 2010, and is now celebrating its 10th year of publication! Thanks to the meaningful contributions from many authors on a variety of topics, nearly 40 issues and 375 articles have been published to date. Recently, you may have noticed a few changes in appearance. To ensure an easier, faster read, articles are now just one page, and the publication itself is no more than eight pages. As always, we are interested in your feedback and also appreciate ideas for new topics. Please send your thoughts to Jennifer Behm at jennifer.behm@chs-mi.com or 989.583.4051.

Congratulations Physicians of the Month!

Your patients and colleagues are saying extraordinary things…

MARCH
Dr. Aaron Smith
EMERGENCY MEDICINE

"It was a friendly experience. The doctor related to my son and made him laugh."

"Dr. Smith was amazing. Super nice, caring and gentle."

"Dr. Smith was caring, knowledgeable and compassionate. Covenant is lucky to have him."

APRIL
Dr. Jane Castillo
FAMILY MEDICINE

"Dr. Castillo is the BEST. She is the most caring and compassionate doctor anyone could have."

"Excellent care from Dr. Castillo. She truly cares about my health."

"Dr. Castillo is the best. She is very thorough and always takes the time to make sure our questions are answered."

MAY
Dr. Michael Davison
FAMILY MEDICINE, MEDEXPRESS

"Dr. Davison explained (things) to me in language I understood."

"The doctor was very personable and informative."

"Dr. Davison communicated very well."

JUNE
Dr. Kimberly Wagner
FAMILY MEDICINE

"Dr. Wagner is a wonderful doctor. I recommend her to everyone."

"I feel like Dr. Wagner is someone who genuinely cares and listens to her patients."

"I absolutely love Dr. Wagner, and the rest of her staff are so nice. I always enjoy my visits and leave with more positive energy than when I arrived."