THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | MARCH 2022

When in Doubt, Sing it Out

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

Well, my friends, it has been two years since we started this craziness with COVID-19 and quite frankly, it is hard sometimes to be positive – even for me!

Everyone has been touched by COVID-19 personally and professionally in one way or another. We have all read countless updates on mandates, had numerous conversations with patients and families about pandemic restrictions, and most unfortunately have had to live with a rollercoaster of uncertainty.

Outside of the deaths we see and hear about, this uncertainty is truly the worst part of the pandemic: the fact that on any given day the goal post gets moved to a different position.

As physicians, we typically are overachievers to begin with, and we usually thrive on challenges and getting to the goal. But when you cannot see a clear goal or always know which direction to take, we get internally fraught with frustration and resentment. We desperately want to see the finish line, but the invisible enemy is not playing fair, which is not boding well for our "get-it-done" psyches.

While I was mulling all this over, it struck me: what else can we do when faced with continued uncertainty? The answer: seek solace in something that you know in your heart is good. For me it is music of all types: classical, jazz, Broadway musicals – oh, I could go on and on. But my point is that music brings ME comfort and certain songs will reset my mind in a nanosecond.

For example, watching the Sound of Music as a kid and listening to Julie Andrews sing "My Favorite Things" has real power for me. There is something so pure in her voice, and while the lyrics can be whimsical like "whiskers on kittens," the song makes my heart sing inside because it is SO positive and reminds us to be positive too – even "when the dog bites."

What are some of YOUR favorite things to do that make you feel good? Is a favorite food dish that your grandmother made for you when you were little that feeds your soul? Running outside in the summer during a warm light rain? Skiing through a powdery snow? Volunteering for a food pantry? Watching your kids find happiness in a new accomplishment?

I am sure that we all have favorite, "feel-good" things we like to do. The challenge is to remember to do them to clear our minds and keep our hearts singing, even when we are feeling sad and tired.

Please take the time to enjoy the things you love most; they are surely the one constant we have in this world.

Sincerely,

K Cowling

Dr. Kathleen Cowling

"When the dog bites,

When the bee stings,

When I'm feeling sad,

I simply remember my favorite things

And then I don't feel so bad!"

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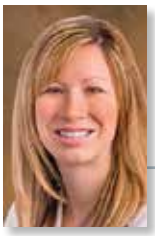


Advanced Clinical Genomics: Getting Ahead of Cancer

Terese Cook, Advanced Clinical Genomics, ACNP-BC, Covenant Cancer Care Center

Due to many advances, cancer genetic testing and guidance is now accessible, affordable and readily available for patients who have concerns about inherited cancer risk. The industry has come a long way since the 1990s when BRCA1/2 mutation testing became the first genetic test to assess cancer risk in the clinical setting. Now in 2022, over 50 hereditary cancer syndromes have been identified.

You likely have patients who can benefit from genetic testing. This article summarizes the process, value and the role you can play.

Overview

Cancer genetic testing is performed using a small sample of body fluid or tissue, usually blood. Several of the most widely used genetic testing laboratories in the U.S. (e.g., Myriad, Ambry and Invitae) now have multi-cancer panels that can assess 70 genes or more at a time. Disruptive variants in these genes have been associated with:

- A multitude of different cancers, such as female/male breast, ovarian, endometrial, pancreatic, prostate, sarcomas, colorectal cancer and polyps, gastric, leukemias and melanoma.
- Non-malignant tumors such as pheochromocytomas, neurofibromas and overgrowth syndromes.

The average test turnaround time is 21 days, depending on insurance approvals, lab workload and other factors.

Value

Both positive and negative results provide useful information.

- **A negative result** offers reassurance and peace of mind to an anxious patient. This can prompt discussions of remaining lifetime risks, enabling the patient to make a more informed decision on the frequency and type of screening, as well as preventative measures based on a more accurate risk assessment. Tailoring preventative screenings to a patient's risk is easier when the inherited condition is ruled out.
- **A positive test result** gives patients the opportunity to not only gather a fuller understating of their family history, but also become an active participant in managing their future cancer risk. For example, women have an approximate 10-12% lifetime risk of breast cancer. For those who have a family history, that risk can jump to 15-25%. For a BRCA1 carrier, the high end of risk is about 88%.

The office visit is comprised of reviewing a patient's test results, their inheritance pattern (usually autosomal dominant), lifetime risk estimates based on their personal/family history, and the variant involved.

Most importantly, discussions take place on how to partner with the healthcare institution to identify cancers in their earlier stages, avoid additional treatments like radiation and chemotherapy, or possibly prevent cancer altogether through preventative surgery. For patients who already have a cancer diagnosis, genetic testing can assist in guiding treatment decisions through targeted therapies and can bring comfort in being able to test blood relatives who may also be at risk.

What Providers Can Do

If you have patients concerned about their inherited risk of cancer, you can talk to them about possible genetic testing. Signs of an inherited cancer syndrome include: cancer diagnosed at a young age, a bilateral cancer, multiple first-degree relatives with the same type of cancer, unusual cancer, birth defects, belonging to a specific ethnic group (i.e., Ashkenazi Jewish) and multiple effected family members.

Usually, genetic testing is covered through health insurance either through a patient's preventative benefits plans or by paying towards their deductible if it is deemed meeting a medical necessity. When it is not covered, affordable self-pay options are available.

Various hospitals, including Covenant HealthCare, offer advanced clinical genomics to interested patients. At Covenant, for example, the Cancer Risk Assessment and Prevention Clinic is dedicated to discussing cancer risks with patients and guiding them in their decision-making.

To make a referral, please see the contact information below.

For more information, contact Terese Cook, ACNP-BC, at 989.583.5060, Option #2. To make a patient referral, enter "Refer to Genetics" in Epic. Appointments can be scheduled at the Cancer Care Center on Mackinaw or virtually at Hills and Dales General Hospital in Cass City.

The Latest on COVID-19 Monoclonal Antibodies

Scott Kollmeyer, PharmD, BCPS, Covenant HealthCare Clinical Pharmacy Administrator

Each monoclonal antibody has different indications, administration types and niches. It is important for physicians to know their differences, understand the predominant circulating variant and which monoclonal antibodies are effective towards them, and know that supply of the antibodies as well as staff to administer treatments can be constrained.

Available Therapies

COVID-19 monoclonal antibodies (mAbs) have been in use by Covenant HealthCare since November 2020 when the Food and Drug Administration (FDA) granted Emergency Use Authorization (EUA) for bamlanivimab.

There are now several COVID-19 mAbs available for treatment that work similarly, as follows:

- **Eli Lilly:** Combines two COVID-19 mAbs, bamlanivimab with etesevimab for treating mild to moderate COVID-19 cases as well as post-exposure prophylaxis in select patients. It is the only COVID-19 monoclonal antibody product authorized in both adults and pediatric patients including neonates. Currently, it is only available as IV infusion. Retains activity against the Delta variant but has reduced susceptibility to Omicron.
- **Regeneron:** Combines casirivimab and imdevimab and treats similar patient types as the Eli Lilly product, can be administered by IV and offers activity against Delta but no activity against Omicron. Key differences: It is limited to adults and pediatric patients 12 years or older that weigh at least 88 pounds, and it can also be administered as four subcutaneous injections.
- **GlaxoSmithKline:** Uses sotrovimab alone for mild to moderate COVID-19, but is not authorized for post-exposure prophylaxis. It is administered through an IV infusion. Retains activity against Delta and Omicron.

Patient Criteria

The FDA EUA patient criteria are largely the same for all authorized monoclonal antibody treatments. However, during times of limited supply, the State of Michigan can set more restrictive criteria that must be followed. In general, mAb candidates:

- Must have mild to moderate disease and be symptomatic but not in need of oxygen or hospitalization.
- Must be within 10 days of symptom onset for the treatment to work while the virus is actively attacking cells.
- Patients must be at high risk for progression to severe COVID-19. The list of conditions and factors can be found here: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

Pros and Cons

The goal of therapy is to reduce the risk of hospitalization and mortality in patients at the highest risk of developing severe COVID-19. Available data suggest that monoclonal antibodies can reduce these risks within 28 days by roughly 75-85%.

Despite this, mAbs are just one tool in an ever-growing tool kit. Vaccines remain our most effective and best option for preventing severe COVID-19. They are widely available and offer patients the ability to make their own antibodies to protect them. The monoclonal antibodies, though helpful for treatment, have some disadvantages:

- They can be in high demand and short supply, and thus not always available when a patient needs them.
- They require significant resources to administer, a problem during staffing shortages. Infusion time plus post-infusion monitoring ties up chair times or results in prolonged ER visits.
- Like vaccines, mAbs are not 100% effective against COVID-19 and have adverse effects too.

Patients receiving monoclonal antibodies must continue to quarantine as directed by the CDC. Patients wanting a vaccine after mAb should wait 90 days – any sooner can reduce vaccine effectiveness.

Current Availability

All the COVID-19 mAbs have been purchased by the United States government, which allows the medication to be offered to patients free of charge. Doses are allocated to the states based on confirmed hospitalizations and cases. Each state further allocates to individual health systems. Allocations are assessed weekly with no guarantees there are enough courses to treat all eligible patients. Availability is constantly changing and difficult to predict -- another reason to get the vaccine.

Between the emergency room and clinic through the Visiting Nursing Association, Covenant HealthCare alone has administered roughly 1,000 doses since authorization.

Please continue promoting vaccinations and educating your patients on their importance, as they are still the best and most reliable way to combat COVID-19.

For more information, contact Scott Kollmeyer at 989.583.4039 or scott.kollmeyer@chs-mi.com.

Molecular Genetic Testing Now Available for Thyroid Nodules

Dr. Christina Maser, General and Endocrine Surgeon, CMU College of Medicine

Thyroid disease is common, with thyroid nodules and cancer significantly rising over the past decade. While the mortality rate remains low, this increase in cases means many more patients need evaluation and management.

About 10% of thyroid nodules harbor malignancy. In 2016, the American Thyroid Association (ATA) published updated guidelines in thyroid evaluation and management of cancer. These changes provide a more patient-centered approach by better defining the characteristics of a concerning lesion, tailoring treatment and reducing overtreatment. The increasing availability of molecular testing also helps patients and providers make more informed decisions.

Initial Evaluation

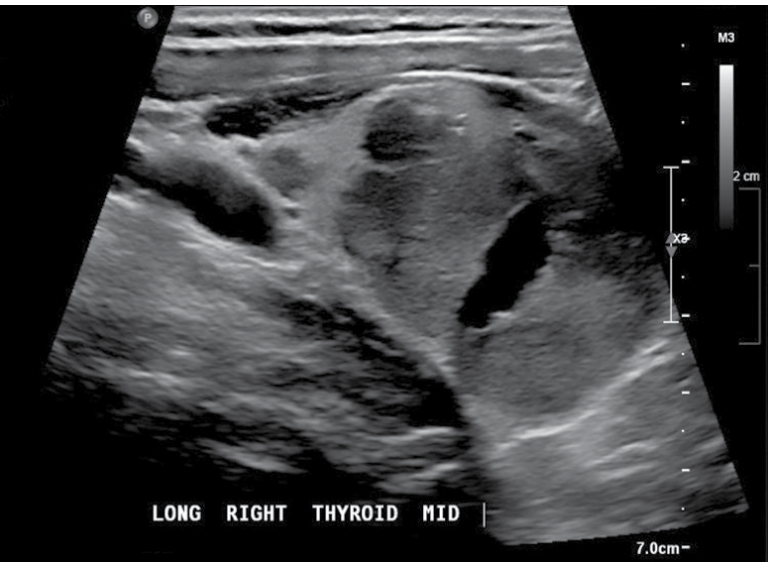
Evaluation begins with measurement of thyroid hormone levels, dedicated thyroid ultrasound (US), and possibly fine needle aspiration (FNA) biopsy. Typically, a TSH and free thyroxine measurement are enough to diagnose abnormal thyroid function. A dedicated US of the thyroid is critical to fully evaluate the nodules.

Based on the US, biopsy may be indicated using the ATA guidelines or the Thyroid Imaging and Reporting Data System (TI-RADS) criteria. Both consider the echogenicity, composition, conformation, extrathyroidal extension and the internal pattern of echogenic foci (calcifications). Previous guidelines used size as the only criteria, recommending biopsy of any lesion greater than 1 cm in size. ATA recommendations allow for clinical interpretation and selective biopsy of lesions between 1 and 2 cm.

Classification

Lesions meeting criteria then undergo FNA. Results are interpreted based on the Bethesda classification system which stratifies the lesion into one of six categories to determine whether the nodule can be monitored with surveillance or if surgical excision is indicated.

INDETERMINATE NODULE



- For benign nodules, surveillance can occur with US.
- If the nodule is suspicious for cancer, surgery is recommended.
- The difficulty lies with nodules which are indeterminate.

Indeterminate nodules correspond to Bethesda category 3 and 4 which demonstrate atypical or neoplastic findings, yet malignancy cannot be determined on FNA alone. These nodules have historically been removed with a hemi-thyroidectomy for diagnosis, potentially followed by completion thyroidectomy if malignancy is found. The overall malignancy rate for Bethesda 3 and 4 lesions varies from 5-40%. For these situations, molecular testing can provide more data to guide recommendations.

Molecular Testing

Molecular testing provides risk stratification for indeterminate lesions. Only certain companies offer this test, which requires two additional samples to be obtained at the time of FNA and placed in a separate medium. If the cytology returns indeterminate, the sample is tested. Results identify specific mutations known to be associated with malignancy as well as the epigenetic markers commonly seen with malignancy.

These results can guide clinical approach. For an indeterminate nodule:

- Molecular testing demonstrating no evidence of suspicious mutations allows 94-97% certainty of benign behavior. Thus, the patient can avoid surgery and preserve their thyroid function for asymptomatic benign nodule.
- If results are suspicious, the lesion is at higher risk of malignancy but this requires surgery for diagnosis. Molecular testing can guide the surgical approach in cases where a high-grade mutation is noted pre-operatively.

While molecular testing can be costly, it is typically covered by patients' insurance. The value it brings to the patient is significant yet difficult to quantify. Results of molecular testing help raise the quality of the doctor-patient discussion when deciding if, when or how much thyroid to remove. Studies have shown that dependency on thyroid hormone long-term can impact quality of life for some patients, so the more informed decision, the better.

Summary

The overall trend in ATA recommendations is to add a sense of precision to the care of thyroid patients. A clinical approach to the patient which includes a carefully considered recommendation for biopsy, in addition to the option to add molecular analysis data to decision making, enables the highest level of care. Molecular testing can be coordinated by most hospitals, including Covenant HealthCare.

For more information, contact Dr. Maser at 989.790.1001 or maser1cl@cmich.edu.

Sacral Neuromodulation: A "Pacemaker" for Overactive Bladder

Dr. Thomas Minnec, Obstetrics/Gynecology, Women's Ob-Gyn, PC

Patients suffering from urge incontinence or overactive bladder (OAB) have a sudden and compelling urge to void right away, impacting their quality of life. Over 50 million adult women suffer from OAB, which is difficult and embarrassing for them, and tough for physicians too when the treatment options do not work and there is no "magic pill." Unfortunately, many patients resolve to just live with OAB.

It does not have to be that way, though. Advanced Sacral Neuromodulation (SNM) treatments are giving hope to many. These patients often report back, in tears, how SNM has changed their lives. Their testimonies are both humbling and rewarding.

OAB Management

OAB can have many causes – from weak muscles and smoking to bad diet and obesity. However, in the absence of a tumor or structural defects, the typical management for OAB starts with behavioral modification, including lifestyle modifications, bladder training and pelvic floor physical therapy.

If those treatments fail, medication therapy is recommended for qualifying patients, but they typically discontinue use within six months for various reasons. Percutaneous tibial nerve stimulation (PTNS) can also be tried if patients refuse or do not tolerate medications. Yet another option is Botox, however most patients refuse due to the chance for urinary retention and the need to self-catheterize for a period of time.

If none of those conservative treatments work, SNM may be an option.

SNM Overview

SNM therapy is an implantable neurostimulator that has been commercially available in the United States for over 20 years and is clinically proven to be safe and effective not just for OAB but for urinary retention and fecal incontinence too. Advances have made it much more effective and convenient. For example, newer devices are:

- Easily and quickly rechargeable.
- Have a 15-year battery life (versus a 3- to 5-year life).
- Can be implanted as an outpatient.
- Feature small, easy-to-use remote controls.
- Are MRI-compatible under approved conditions.

The technology is straightforward. The sacral nerve controls the bladder, bowel, pelvic floor and related muscles. A small SNM stimulator device implanted under the skin sends mild electrical impulses to the S3 sacral nerve to regulate and improve bladder/bowel control, and to restore faulty bladder control communications from the brain.

SNM Success and Criteria

SNM is increasingly being used to treat urinary incontinence, urgency, frequency, non-obstructive retention and fecal incontinence with great success. According to one manufacturer (Axonics):

- 93% of treated patients achieved clinically significant improvements at 2 years.
- 94% of patients were satisfied with their therapy, and 93% said they would undergo the treatment again.
- 89% of patients experienced 50%-plus reductions in urinary urge incontinence symptoms.
- Less than 2% of patients reported discomfort at their implantation site.

SNM candidates, however, must first pass a set of criteria including:

- First, try and fail conservative treatments.
- Be 18 years or older.
- Not have diabetes or a neurological disease like multiple sclerosis.
- Be able to operate the system cognitively and physically.
- Demonstrate an appropriate response to test stimulation before implantation.

Our Responsibility

It is our responsibility as healthcare providers to ask every patient about their urinary health, treat it when comfortable with the management protocols and refer to a specialist when necessary.

Women should never be told that incontinence is a normal part of aging and to "live with it." OAB can be treated with many modalities, including the conservative treatments described above or with SNM therapy. Together, we can give them hope to get their life back.

For more information, contact Dr. Minnec at 989.792.3100 Dr.Minnec@womensob.com.

"You are not alone with overactive bladder. Many women have this problem. After other treatments did not produce the results I was looking for, I thought there was nothing left to try. SNM was the one that finally worked. I am now able to sleep through the night! Staying dry between bathroom visits during the day makes me especially happy."

— FRAN, AN SNM PATIENT

Diagnostic Imaging: Preventing Over-Exposure

Dr. Lodewijk van Holsbeeck, Diagnostic Radiology

When a patient presents with an injury or persistent pain, ordering a diagnostic image is usually the first thought when trying to diagnose the condition. However, it is a good idea to think twice for two key reasons:

1) Too much imaging that emits ionizing radiation can cause undue harm to patients over time.
2) Unnecessary testing adds up to needless costs. In fact, some experts estimate that $200 billion is wasted every year on excessive testing.

Imaging will always be a critical part of the diagnostic arsenal, but there is a growing concern that it is used too often for initial diagnosis. To protect patient health, we are all being asked to balance the need to diagnose patients accurately without ordering avoidable tests.

Over-Exposure Issues

Over time, radiation exposure can damage tissue and genetic material and potentially cause cancer. Children, in particular, are more sensitive to radiation effects and the anxiety caused by some imaging tests. Plus, there are the deterministic effects of over-exposure to consider, such as hair loss, cataracts and skin injury.

We can help reduce ionizing radiation exposure by understanding the tests that use it and potential alternatives, and by asking yourself, the patient, and the radiologist the right questions to make the right choices.

ACR Appropriateness Criteria for Imaging

Before ordering diagnostic imaging, review the most current evidence-based guidelines to assist in making the most appropriate decisions for any given clinical condition. See:

https://www.acr.org/Clinical-Resources/ACR-Appropriateness-Criteria

Understanding Test Choices

Every day, we all face natural sources of ionizing radiation (sun, solar, terrestrial) but our main exposure is from diagnostic medical imaging.

- Tests that emit ionizing radiation include X-rays, computed tomography (CT/CAT), positron emission tomography (PET), fluoroscopy and nuclear medicine procedures.
- Tests that do NOT emit ionizing radiation include magnetic resonance imaging (MRIs) and ultrasound (US).

Making the Right Choices

When ordering imaging, the current motto is to follow ALARA or "as low as reasonably achievable" in terms of radiation exposure. Questions that medical doctors should ask include:

- What is the risk/benefit of obtaining a diagnostic or therapeutic imaging test?
- Is imaging really needed? Is it needed now and will MRI or US give me the data I need?
- What is my patient's imaging history in the past few years?
- What is the radiologist's opinion and recommendation for this patient?

If a CT is warranted, keep in mind that these scans deliver about 70% of the medically-related radiation dose to the general U.S. population. The radiologist, however, may be able to reduce exposure in two key ways:

- CT optimization to minimize the absorbed dose while maintaining image quality and patient safety.
- Avoiding multiphase CT in favor of single-phase CT.

In addition, for all imaging, it is important to stay current and follow the American College of Radiology (ACR) Appropriateness Criteria to avoid inappropriate referrals (see sidebar link below). Also, try to resist patient wishes for imaging you feel is not necessary. Explain to them the risks and benefits so they clearly understand why the choice is a good one for them.

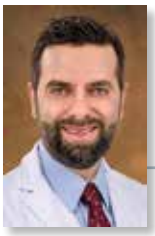
Provider Collaboration

No one doctor can achieve alone what a group of us can do together for the good of each patient.

Communication between clinician referrers and radiologists is indispensable in justifying decisions and in obtaining a well-thought-out and non-wasteful imaging plan.

Such collaboration has, for example, led to many pediatric and adult cases being initially imaged using US, which is less expensive, readily accessible and requires no radiation. Referring clinicians can also work with the radiologist to confirm that the US findings do or do not need any further imaging workups. This reflects a cautious and responsible approach to patient care that ensures patient safety and the best possible outcomes.

For more information, contact Dr. van Holsbeeck at lvanholsbeeck@adirads.com.



Peripheral Artery Disease: Causes, Symptoms and Management

Dr. Anwar Zaitoun, Cardiac and Peripheral Interventionalist

According to the Centers for Disease Control and Prevention, approximately 6.5 million people over 40 years old in the United States have peripheral artery disease (PAD). PAD is caused by progressive atherosclerosis and stenosis of peripheral arterial beds. Risk factors, including dyslipidemia, diabetes mellitus, hypertension, smoking history and high blood pressure, are known to be linked to developing PAD.

There is also a higher risk of getting PAD for those of African American descent. In addition, a history of coronary artery disease, previous cerebrovascular event or carotid artery disease increases the likelihood of developing PAD in the future.

Early detection and referral to a PAD specialist can significantly reduce the burden of symptoms from PAD. Also, medical management and following a structured exercise program have significant impact on a patient's quality of life and can significantly reduce the risk of developing complications from PAD, such as non-healing wounds and amputation. Moreover, strict risk factor modifications will decrease the risk of developing atherosclerotic disease elsewhere (cardiac or cerebrovascular disease), preventing myocardial infarction or strokes.

Below is a brief review of PAD symptoms, diagnosis and treatment.

Symptoms

PAD symptoms can vary as some patients might be asymptomatic in the early stages. However, the onset of PAD begins with extremity muscle pain or a burning sensation that starts with walking and disappears with resting, known as claudication. Claudication can be described sometimes as exertional burning sensation of the affected extremity.

PAD effects the lower extremities arterial tree. However, it can also affect the upper extremities causing similar symptoms. If PAD is left untreated, symptoms would progress over time and patients might complain of symptoms even with minimal activity or at rest. Additionally, severe PAD can result in chronic non healing ulcers and infections that will be resistant to antibiotics therapy if not treated. Of note, PAD can result in impotence as well if iliac arteries are involved.

Diagnosis

Diagnosis of PAD can be confirmed with different testing modalities including ankle-brachial index (ABI) and arterial Doppler/duplex. If indicated, further evaluation with imaging modalities including CT angiography or peripheral angiogram can provide detailed anatomical description of patient's disease.

PAD management

After establishing a diagnosis of PAD, medical treatment is indicated in all patients to prevent progression of the disease, alleviate the symptoms and minimize the risks discussed above.

PAD management with aspirin and high-dose statin, regular exercise and counselling regarding smoking cessation is recommended for all patients. In some patients, the addition of cilostazol might be required to alleviate the symptoms of claudication. If symptoms persist, peripheral angiogram and intervention using endovascular techniques is usually considered. Surgical bypass is considered in certain patients with recurrent occlusions or for patients who failed previous endovascular therapy.

Summary

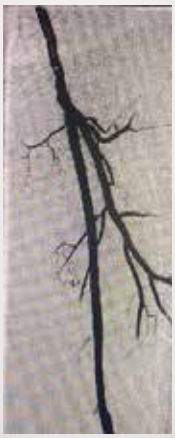
Screening for PAD is recommended for patients older than 70 years old, or age 50-69 with history of tobacco use or diabetes, or in case of absent pedal pulse, by obtaining ankle-brachial index. If ABI is less than 0.90, then diagnosis of PAD is established. ABI can be falsely normal (>0.9) or extremely elevated (>1.3) in patients with advanced renal disease or progressive diabetes, and with axillary/brachial artery stenosis. Thus, referral to a specialist is recommended.

PAD Case Study

A 64-year-old female has claudication of left leg despite medical therapy. The patient's left ABI was 0.5. A peripheral angiogram showed occlusion of the left superficial femoral artery. This was successfully treated percutaneously with stenting, reducing stenosis to 0%. Following intervention, her left leg claudication resolved. A repeat ABI was normal and she was able to resume activities without pain.

See the images below for pre- and post-stent results.

Totally occluded left SFA.



No occlusion after treatment.

For more information, contact Dr. Zaitoun at anwar.zaitoun@chs-mi.com, or call 989.583.4700.

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The Chart Spotlights

Congratulations Providers of the Month!

Your patients and colleagues are saying extraordinary things…

JANUARY

Dr. Brian Purchase, Sports Medicine

"Dr. Purchase is a knowledgeable, professional and empathetic physician."

"Dr. Purchase is a very kind and considerate physician that tries to resolve my problems."

"Dr. Purchase goes above and beyond for his patients. He truly cares. I highly recommend him and his office."

FEBRUARY

Dr. Mayar Jundi, Cardiovascular Medicine

"Dr. Jundi is extremely good at explaining and caring as a true professional. I have and will continue to recommend him to others."

"Dr. Jundi is a wonderful man and takes so much pride in his work for his patients."

"Dr. Jundi is outstanding!"

MARCH

Dr. Karensa Franklin, Family Medicine

"I wouldn't hesitate to recommend Dr. Franklin to others. She's very knowledgeable, personable and is willing to answer all questions."

"This doctor was very nice and helpful with everything I needed."

"Dr. Franklin and staff are tremendous assets to Covenant HealthCare."