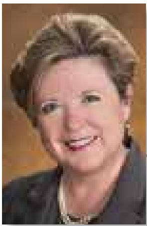
THE COVENANT Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | SEPTEMBER 2021



Back To School and Basics

Dr. Kathleen Cowling
Covenant HealthCare Chief of Staff

This time of year, it's hard to go anywhere without seeing "Back to School" signs. To me, it's a reminder to get "Back to Basics" in healthcare too.

Think about it. Kids typically look forward to renewing friendships, starting relationships and enjoying new experiences. Even so, there is usually a little anxiety and uncertainty when they return to school – especially after the COVID-19 shutdowns. Can they hug friends? Will teachers be friendly? Will school be fun?

The same can be said about healthcare providers, except that we are also dealing with the huge dimension of change surrounding healthcare. While COVID-19 precautions have saved many lives, they have also created some awkwardness with each other and patients, and a slew of unusual stressors.

The solution is to *get back to basics* by taking back the important things we lost and by creating a new level of trust, respect and stability.

Accept the Suffering

The book, *No Mud, No Lotus,* by Thich Nhat Hanh (a Vietnamese monk and peace activist), explains how the secret to happiness is to acknowledge and face our suffering rather than bury it. In this way, we can find mindfulness, peace and balance in our lives. The pandemic is a stark example of suffering on many levels. Shedding the moral residue we experienced, and the fragility we feel, is tough. But by accepting that we experienced it, and that life has so many joys to offer every day, we can avoid feeling so overwhelmed.

Find a Healthy Balance

The pandemic has left many of us with a new sense of urgency about life, and a different kind of burnout. Our bucket lists have changed, causing some to "run" from their jobs across industries. At the end of the day, we can and SHOULD find a healthier balance by diving into new experiences. But let's do that responsibly since our patients – and colleagues – rely on us to be there when they need us. For example, plan ahead for that two-week trip to minimize interruptions, and remember to follow up with patients after you see them rather than leave that task to others.

Erase Some Space

At least 70% of communication is nonverbal, but it has been significantly hampered by masking and distancing. Plus, misinformation is driving continuing fear. Together, let's assuage patient concerns about seeing their physicians, going to urgent care or ER, getting vaccinated and so much more. From improving our body language, to bringing more laughter and recognition to the workplace, to increasing personal follow-ups with patients, we can increase trust and camaraderie.

Advocate for Change

Is the year ahead full of new initiatives or the same old curriculum? Maybe now is the time to advocate for the change you want to see. As the physician body, it is **our** responsibility to speak up and encourage improvement. It is up to **us** to connect with elected politicians and have conversations about healthcare issues like equal access to medications and rising medical bills.

In summary, maybe now that the worst of the pandemic has hopefully passed, we can accept it, learn from it and move on in positive ways. We can appreciate the joys of life, restore balance and stability, rebuild relationships and slay some of the dragons that were always there, but are now more obvious.

Sincerely,

K Cowling

Dr. Kathleen Cowling

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Telehealth Laws: Opportunities and Challenges Ahead

Dr. Arshad Aqil, Internal Medicine

Prior to COVID-19, per section 1834(m), most Medicare beneficiaries were barred from using widely available two-way audiovisual technologies to access covered telehealth services unless they lived in a rural area or in certain facilities, with few exceptions.

In response to the COVID-19 public health emergency (PHE), Congress passed the CARES Act, which provided the Centers for Medicare and Medicaid Services (CMS) the authority to waive those restrictions during COVID-19. This led to a meteoric surge in telehealth usage among Medicare and other beneficiaries as patients could, for the first time, access telehealth services from wherever they are located.

CMS added Medicare coverage for more than 150 services for the PHE duration, increased payment for telehealth services to be equivalent to in-office rates and allowed for a patient-physician relationship to be established via telehealth platforms.

As we approach what is hopefully an end to the PHE, we must ensure that it does **not** signal an end to telehealth progress too.

Protecting Progress

Milton Friedman said, "Only a crisis – actual or perceived – produces real change." Telehealth is one such change that has altered patient care forever.

Among other benefits, it has created access to care for broad patient populations, especially for vulnerable minority and rural groups. Numerous surveys show that telehealth is quickly gaining acceptance among all groups and is changing how patients perceive care. For example:

- In a recent COVID-19 Healthcare Coalition survey, 79% of patient respondents reported satisfaction with their telehealth visit. Most patients also reported that telehealth removed barriers to care, increased convenience and lowered costs.
- In a McKinsey & Company telehealth survey, healthcare providers are growing more comfortable using telehealth services, with 64% reporting increased comfort since the start of COVID-19.

Ensuring Reimbursement

For providers to continue delivering high-quality patient care through telehealth and other virtual services, they need adequate reimbursement not just for virtual medical services, but also for the plethora of HIPAA-compliant technologies, infrastructure costs and training they incur. Otherwise, they may be forced to decrease their telehealth offerings which can reverse progress. Note that:

- In the COVID-19 Healthcare Coalition survey, more than 73% of respondents cited low or no reimbursement as a barrier to maintaining telehealth usage after COVID-19.
- Other challenges include lack of patient access to technology devices, lack of education or comfort level, privacy and liability concerns, cultural barriers and interstate licensure and regulatory issues.

Taking Action Legally

The Center for Connected Health Policy (CCHP) is tracking over 100 pieces of bipartisan legislation seeking to expand and strengthen telehealth. The majority of recently introduced bills are focused on telehealth reimbursement with some bills requesting funding for telehealth services and infrastructure.

More specifically, these various bills call for:

- Lifting of CMS geographic and site limitations
- Lifting of clinician restrictions to remotely monitor/track patient health and provide access to digital devices
- Improving broadband access
- Rural remote monitoring
- Telehealth coverage in high-deductible plans
- Payment parity for audio-only telehealth
- Coverage for patient treatments at home
- Rural health clinics and federally qualified health centers serving distant sites through telehealth

The Cures 2.0 bill also addresses much of the above and more, such as encouraging telehealth collaboration and metrics, and helping states integrate telehealth into their Medicaid and Children's Health Insurance Program. It is hoped that this will be signed by the fall.

Such actions are also supported by the American Hospital Association (AHA) which, among other things, is strongly urging Congress to make the PHE changes permanent by eliminating 1834(m) restrictions, and strongly supporting continued coverage and reimbursement for audio-only services.

Strong federal support, public demand, advocacy from healthcare groups and providers and proven telehealth outcomes will all help secure the future of telehealth while ensuring safe, quality care.

For details about current legislation, search for the following CCHP article online: *New Wave of Federal Bipartisan Bills to Expand Telehealth*.

For more information, contact Dr. Aqil at 989.980.8487 or arshadaqil1@gmail.com.

Milton Friedman said, ***"Only a crisis – actual or perceived – produces real change."***
Telehealth is one such change that has altered patient care forever.

"Oh, My Aching Back!" – Conservative Therapy for a Common Complaint

Dr. Kevin Orloski, Physiatry

An estimated 60-70% of people across the United States will experience back pain sometime in their lives. Back pain is the second leading reason for visits to primary care physicians (PCPs), accounting for 73 million outpatient visits each year. An estimated 5-10% of patients who initially visit a PCP for low back pain will ultimately develop chronic back pain. Most back pain, however, can be treated successfully without surgery or other invasive procedures.

Value of Conservative Management

Conservative management is an approach to treating back pain, neck pain and related spinal conditions using non-surgical treatment options, such as physical therapy, medication, injections, spinal manipulation and massage therapy. Conservative therapy can also include lifestyle changes, such as exercise and weight loss, that help improve and manage symptoms.

Key benefits to hospital systems and patients include:

- Timely treatment
- Cost-effective, providing relief before expensive imaging and testing is done
- Non-invasive, offering a safer option than surgery with less complications and adverse events
- Possible avoidance or delay of surgery

Hallmarks of a Quality Outpatient Spine Program

Sending patients to a quality outpatient spine program may provide just the relief your patient needs. Important program capabilities include having a PMR physician, physical therapists and occupational therapists on staff, massage, manipulation, quick access to X-ray, fluoroscopy and interventional spine techniques.

More specifically, patients should have access to the following services:

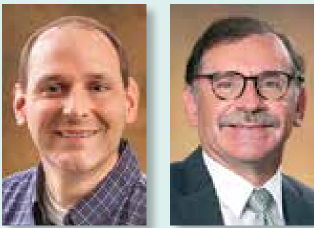
- **Brace fabrication and fitting:** Spinal braces to stabilize, immobilize and correct various spine abnormalities.
- **Electrodiagnostics:** Electromyography and nerve conduction velocity (EMG/NCV) testing to reveal nerve damage in cases of radiculopathy or peripheral neuropathy.
- Functional capacity assessment (FCA): The ability to measure the functional physical ability of a person to perform a work-related series of tasks. An FCA is used to develop a treatment program, measure the physical abilities of patients before and after a rehabilitation program, modify a rehabilitation treatment, evaluate whether an injured worker can work, and determine when he/she can return to work.
- **Physical therapy (PT) evaluation and treatment, including the McKenzie Method®:** PT aims to ease pain and help patients function, move and live better using various modalities, such as active exercise, passive modalities and manual therapy. The McKenzie Method is a system of assessment and management for spinal and extremity musculoskeletal disorders widely used worldwide for more than 60 years. Clinicians are able to assess and classify all complaints of the musculoskeletal system and develop the appropriate management plan.
- **Return-to-work therapy:** Physical conditioning programs, variously called work conditioning, work hardening and functional restoration/exercise programs, aim to improve work status and function.

Such capabilities are offered at the Mary Free Bed at Covenant HealthCare outpatient spine program – with interventional spine services available in late 2021.

Finding Relief for Your Patients

Chronic back pain may be avoided by early intervention, including conservative management. If your patient's pain is not going away with ice, heat, movement, stretches, NSAIDs or medical creams, don't wait too long to refer them to an outpatient spine program. Co-treating with PT, for example, has proven to benefit patients with pain relief while shortening their recovery time. Together, we can get them back in action.

For more information, contact Dr. Orloski at 989.583.2720 or kevin.orloski@chs-mi.com.



The Reality of Inpatient and Primary Care After COVID-19

Dr. Deibel, Covenant HealthCare Emergency Medicine Medical Director and
Dr. Ronald Gonzales, Family Medicine

Below are two relatable perspectives about the impact of COVID-19 on healthcare in the inpatient and primary care provider (PCP) settings.

Inpatient View, Dr. Deibel

Disease Trends: Unfortunately, patients entering hospitals today tend to be sicker than they were pre-COVID-19. Concerns about infection delayed their presentation until their disease became worse. In addition, while mask wearing decreased the volume of viral illnesses and pediatric fevers, incidents are growing as people mix more.

Changes in Medicine: The most obvious changes are masking and wearing personal protective equipment (PPE). Because COVID-19 is so contagious and can spread without symptoms, it is a constant concern. One positive change is the growth of telehealth, with providers and patients alike becoming more comfortable with it. We should continue to explore this and other ways to make care easier.

A Time for Healing: With COVID-19, we lost some stability due to ongoing uncertainty and stress. Many are suffering from post-traumatic stress disorder whether they realize it or not. It will take time to heal and not everyone will progress at the same rate. Healing starts with taking care of yourself and your loved ones at home, and having the leadership support and resources at work. We can accelerate healing by reaching out with kindness and lifting each other up.

Moving Past the Fear: Contracting COVID-19 is less of a concern for people who have been vaccinated. Still, it will take time to get comfortable with regular routines and we must do our best to accommodate lingering fears. A few steps include:

- Moving back to regular meetings, focusing on topics other than COVID-19.
- Recognizing the importance of teamwork and relying on each other's expertise. We have proven that we can do hard things well and rapidly respond to new challenges – now better than ever.
- Accept that COVID-19 is not gone and that we will continue to deal with it. It should be considered in our workflows.

Primary Care Provider View, Dr. Gonzales

Emotional Upheaval: COVID-19 has demonstrated how vulnerable we are. With the virus came much emotional turmoil in healthcare – from high anxiety to the fear of dying or infecting families and friends, to elation about the acts of appreciation shown by many. It is a rollercoaster many are still riding.

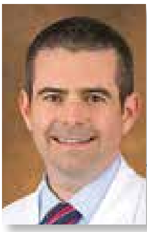
Changes in Medicine: Physicians in the ambulatory arena experienced a reset in maintaining a clean environment for patients. Masking, gloving, gowning and wiping surfaces were done regularly, but are now done constantly. You will not see waiting room drinking fountains, communal magazines, kids' toys or packed seating. You **will** see more virtual visits for situations that allow this. Population health and working together across the community and healthcare, will be emphasized for the future.

Restoring Trust: Some respect for scientific methods was lost, and we must get it back to restore trust. Fear drove many (including some in the medical field) to cling to false hopes or reject information based on real data. We must "clean our house" and improve communications to patients, neighbors and communities. PCPs are especially positioned to address fears because they garner the trust of patients and communities, which is an opportunity for education.

Staff Discussions: The vaccine and related fears should be discussed with staff and co-workers. Regular conversations, including ideas for a better working environment, invests everyone in workplace safety. Providing protection via PPE or plastic guards can help staff feel safer from COVID-19 and other infectious diseases.

The Reality of Globality: COVID-19 has taught us how small the world can be. While world travel allows us to experience foreign cultures, it also hastens the spread of disease. If we fail to understand that diseases do not stop at a line on a map, we should be prepared to suffer the ravages of future pandemics. Continuous education, preparation and cooperation are a must to prevent future issues.

For more information, contact Dr. Gonzales at 989.583.7513 (ronald.gonzales@chs-mi.com) or Dr. Deibel at 989.583.6022 or mdeibel@chs-mi.com.



GammaTile Therapy – Improving Survival from Recurrent Brain Tumors

Dr. James Fugazzi, Covenant HealthCare Radiation Oncology Medical Director

With continued advances in treatment therapies, patients are living longer with cancer. This means that a subset of patients with brain tumors will develop locally recurrent disease. Most of these patients will have already received some form of high-dose post-operative radiation, including standard fractionated external beam over six weeks (along with chemotherapy), or stereotactic radiosurgery (SRS).

Previously, options to deliver additional radiation have been limited due to dose constraints of the normal surrounding brain tissue. Not anymore, thanks to a new GammaTile Therapy that is proven to extend survival from locally recurrent brain tumors with minimal complications.

Technology Overview

Patients who have controlled systemic disease, as well as imaging and clinical characteristics of recurrent brain disease, may be eligible for repeat craniotomy. Those who have a positive pathology (frozen section) at the time of surgery may then qualify for GammaTile Therapy, a new FDA-approved device. GammaTile is a surgically targeted radiation therapy (STaRT) device that provides immediate, dose-intense localized radiation (radioactivity) at the completion of maximum, safe re-resection. This procedure is performed by a neurosurgeon under the guidance of a radiation oncologist and radiation physicist.

The Covenant Radiation Center, in conjunction with the Covenant Department of Neurosurgery, is offering GammaTile Therapy, another tool in the fight against brain tumors for patients with recurrent primary and metastatic brain tumors.

Key Advantages

GammaTile is a conformable, porous collagen tile with four embedded cesium-131 brachytherapy seeds. Each tile measures 4 mm x 20 mm, and the individual cesium seeds have a half-life of nearly 10 days. Essentially, 50% of the therapeutic dose is delivered within the first 10 days after implant, allowing immediate dose delivery to prevent any residual tumor from repopulating. Approximately 88% of the therapeutic dose is delivered within 30 days and >95% by six weeks.

Suitable patients include those able to undergo a safe, maximum re-resection of their recurrent brain tumor. Immediately after resection, several tiles are implanted into the surgical cavity. These tiles allow a uniform, accurate delivery of dose to surrounding brain tissue, enhancing outcomes.

Other important advantages include limited radiation exposure of healthy tissue, "built-in" treatment compliance, reduced patient burden in terms of time, travel and cost, and preserved quality of life.

Approved Patients and Local Availability

GammaTile is FDA-approved for the following patients with:

- Recurrent, high-grade gliomas (HGG) who have received prior radiation.
- Recurrent, brain metastasis who have received prior radiation.
- Recurrent aggressive meningiomas who have received prior radiation.

As the first hospital to offer GammaTile Therapy in Michigan, Covenant HealthCare anticipates using this device for recurrent HGGs and brain metastasis in the initial phase. Other, less frequent indications include upfront treatment for operable brain metastasis, malignant meningiomas, and an upfront "boost" for HGGs followed by immediate radiation (on trial).

Summary of Clinical Trials

In published clinical trials, GammaTile has been shown to extend local recurrence-free survival. Compared to those who did not receive GammaTile, the median local control (LC):

- For HGG patients, was 12.0 vs. 9.5 months (HR 0.6, p = 0.13).
- For meningioma patients, was 48.8 vs. 23.3 months (HR 0.24, p = 0.01) and for brain metastasis the median LC has not been received vs. 5.1 months for those without GammaTile.

Side effects, including wound infections, dural closure-related issues and surgery-related hematoma formation were no different compared to standard neoplasm surgery. In addition, once the dura and cranial bone have been put back into place, there is minimal exposure to hospital personnel and family members. Basic radiation precautions are given. There are also no contraindications for the use of systemic therapy (chemotherapy).

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

How Did Covenant HealthCare Achieve Leapfrog Hospital Safety Grade of "A"?

Dr. Michael Sullivan, Covenant HealthCare Chief Medical Officer and
Tracie Hopkins, Accreditation and Regulation Administrator, Covenant HealthCare

Hospitals nationwide strive hard to distinguish themselves with a Leapfrog Hospital Safety Grade of "A." This prestigious achievement, which is issued twice yearly, demonstrates a hospital's ability to consistently drive patient safety by minimizing errors, injuries, accidents and infections.

It also demonstrates the healthcare industry's effort to improve transparency, high-value care and the ability for patients to make more informed healthcare decisions. In spring 2021, The Leapfrog Group announced the latest grades for 2,700 hospitals, using up to 27 measures of publically available data. Of these hospitals, 33% received an "A," including Covenant HealthCare.

Culture of Commitment

Just how did Covenant HealthCare achieve that distinction for the sixth time in a row? The underlying reason is its culture of dedicated providers and commitment to embed safety and quality into every activity at all levels. According to Leah Binder, president and CEO of The Leapfrog Group, "The past year (with the pandemic) has been extraordinarily difficult for hospitals, but Covenant HealthCare shows it is possible to keep a laser focus on patients and their safety, no matter what it takes."

Examples of Success

Below are examples of success that cross two key performance measurement domains: 1) process and structural, and 2) outcomes.

- Covenant has increased the functionality of Computerized Physician Order Entry (CPOE) over the past few years with upgrades and provider training. The target is for more than 85% of all orders to be placed by the physician, which includes verbal orders. The average for Covenant is approaching that top-performing score.
- Bar Code Medication Administration (BCMA) compliance involves using two patient identifiers to validate the patient prior to administering medication, and following the "five rights:" right medication, dose, time, route and patient. Covenant BCMA rates have improved, despite a slight dip due to the isolation challenges of COVID-19 patients that required some work-arounds. For example, because nurses could not take medication charts into the room, they used an alternative process to maintain patient and medication safety, and isolation precautions.
- Covenant employee and provider surveys help assess and improve its culture of safety. Leapfrog realizes the value of employee feedback and scores accordingly.
- Leapfrog recognizes that hand hygiene (HH) is the number one action all hospital providers and staff can take to reduce and prevent infections. Covenant increased the monthly HH observations to 200 per month per unit to ensure everyone is practicing this safety behavior more than 95% of the time.
- Patient experience scores specific to doctor and nurse communication, medications and discharge are weighted and scored. These activities help Covenant patients return home safely with a good understanding of their discharge plan and greater compliance with medications.
- Hospital-acquired infections and complications after surgery comprise the majority of outcome measures as hospitals are scored on their ability to prevent harm. At Covenant, infection rates that are hospital acquired or that occur after surgery have decreased over several years. The HH campaign, adherence to best practice pre-op, intra-op and post-op, and the increase use of laparoscopic and robotic procedures have all influenced these rates, producing a lower rate of infection.

Details about the Leapfrog Hospital Safety Grade are available on https://hospitalsafetygrade.org. For specific hospital performance across all measures, use the website's search field. Covenant is committed to retaining its grade of "A" through continuous improvement, from increasing HH observations to enhancing surgical protocols and promoting medication safety.

For more information, contact Tracie Hopkins at 989.583.6604 or traciehopkins@chs-mi.com.

Preventing Contrast-Induced Acute Kidney Injury

Dr. Manoj Sharma, Cardiology

Contrast agents for CT scans, percutaneous coronary interventions (PCIs) and peripheral interventions are considered safe with rare adverse effects. However, they can cause acute kidney injury (AKI) in some patients. Contrast-induced AKI (CIAKI) – also known as contrast-induced nephropathy (CIN) – is a mounting issue as our aging population grows and requires more diagnostic procedures. This population has a higher likelihood of comorbid conditions such as diabetes, hypertension and peripheral vascular disease which, when coupled with AKI, can increase their risk of mortality, bleeding, myocardial infarction (MI) and more.

Consequently, CIAKI is a benchmark of quality for cardiac catheterization laboratories and hospital performance. Therapeutic options are limited once AKI develops, so prevention is essential. The National Cardiovascular Data Registry (NCDR) and Blue Cross Blue Shield of Michigan Cardiovascular Consortium are monitoring the data for each institution.

CIAKI Defined

Contrast AKI mechanisms are ischemic (due to renal vascular vasoconstriction) and chemotoxic (direct tubular injury). It may also rarely occur due to atheroembolism caused by cholesterol microparticles from catheter manipulation.

- **Definition:** Rise in serum creatinine (sCr) ≥0.3 mg/dl or a ≥50% elevation from baseline.
- **Extent of problem:** Per NCDR data, 7.1% of patients undergoing PCIs experienced AKI with 0.3% requiring new dialysis.
- **AKI impact:** AKI is strongly correlated with MI, bleeding, longer stays and readmission. Per the NCDR data:
  - Non-CIAKI Patients: 2.1% MI, 1.4% bleeding, 0.5% death
  - Patients with CIAKI: 3.8% MI, 6.4% bleeding, 9.7% death
  - Patients with CIAKI-related dialysis: 7.9% MI, 15.8% bleeding, 34.3% death
- **Predisposing factors:** Greater than age 75, diabetes, pre-existing renal disease, congestive heart failure, ACE inhibitor or angiotensin receptor-blocking medicines, presence of other nephrotoxic agents (NSAIDs, ACEIs, ARBs), hypotension, dehydration and anemia.

Prediction and Prevention

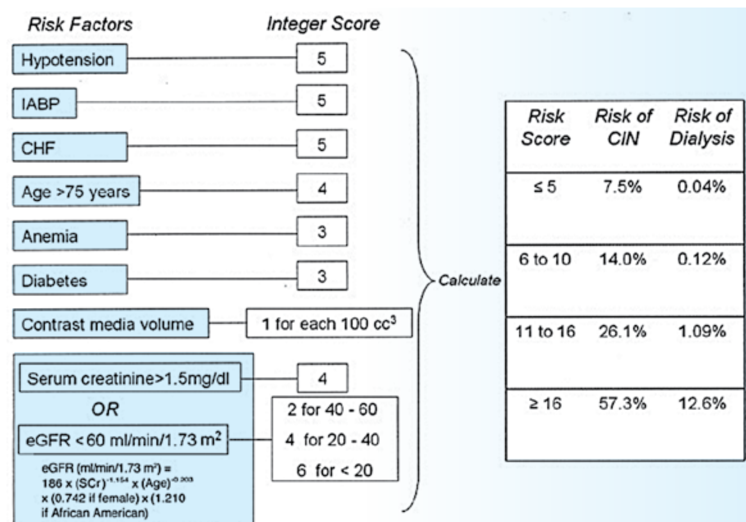
Providers should assess risk factors, ensure hydration and limit contrast dosing. More specifically:

- Review renal function prior to ordering a test requiring contrast.
- Evaluate patient history for any of the predisposing factors listed above.
- Ensure no recent contrast administration within 48 hours, at least.
- Ensure proper hydration prior to and after the procedure.
- Limit contrast volume by using ultra low volume contrast protocols and zero contrast PCI protocols whenever possible.
- Consult with nephrology.

Education and Protocols

Many hospitals are implementing CIAKI prevention protocols, including Covenant HealthCare. Two key Covenant initiatives, for example, are already being implemented: 1) the Save the Kidney Campaign to educate all nurses, hospitalists and advanced practice providers about newer CIAKI protocols, and 2) a CIAKI Prevention Toolkit. Below is a summary of key practices:

- Use risk calculators / Mehran score charts to predict risk of CIAKI prior to contrast. Pre-catheterization (see below) orders from ordering physicians will require a Mehran score too.
- Implement updated pre- and post-procedural hydration protocols based on national standards.
- Limit contrast volume; the risk of CIAKI increases by 12% for every 100 ml of contrast administered. Monitor patient for contrast volume/calculated creatinine clearance ratio which should be kept less than 3 and ideally less than 2. Encourage practical methods to lower contrast volume too, such as limiting the number of injections, using ECHO in lieu of left ventriculography or using intravascular ultrasound.
- Correct modifiable risk factors for CIAKI, such as peri-procedural hypovolemia, hypotension, hyperglycemia and anemia, and hold nephrotoxic drugs.
- Flag patients who were exposed to contrast in the past 48 hours and postpone procedure (if clinically feasible).
- Obtain follow-up labs to diagnose CIAKI and monitor patients for recovery.
- Ensure progress by comparing performance to national benchmarks and modifying strategies to minimize risk.



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The Chart Spotlights

Congratulations Providers of the Month!

Your patients and colleagues are saying extraordinary things…

JULY

Dr. Joseph Natole, FAMILY MEDICINE

"Dr. Natole is probably the best doctor I have had in my life. He is easy to talk to and very attentive to detail."

"Dr. Natole always takes the time to discuss any health issues and does a great job answering any questions."

"Dr. Natole is excellent in every way. I would recommend him highly to anyone."

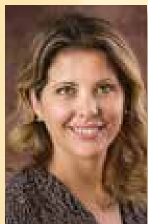
AUGUST

Dr. Ronald Barry, PLASTIC SURGERY

"Dr Barry takes pride in the care of patients. He ensures he is able to meet with all patients prior to surgery to answer any questions and is a perfectionist in the operating room, demonstrating his commitment to excellence."

"Dr. Barry always takes excellent care of each of his patients; he goes above and beyond."

"Dr. Barry was wonderful; he is professional and kind."



SEPTEMBER

Dr. Nicole Sinclair, PEDIATRIC CRITICAL CARE

"Dr. Sinclair is a brilliant physician. She always remains calm and compassionate, even in the most stressful moments."

"Dr. Sinclair was very nice and helpful."

"Dr. Sinclair is smart and very approachable; she is always willing to help."