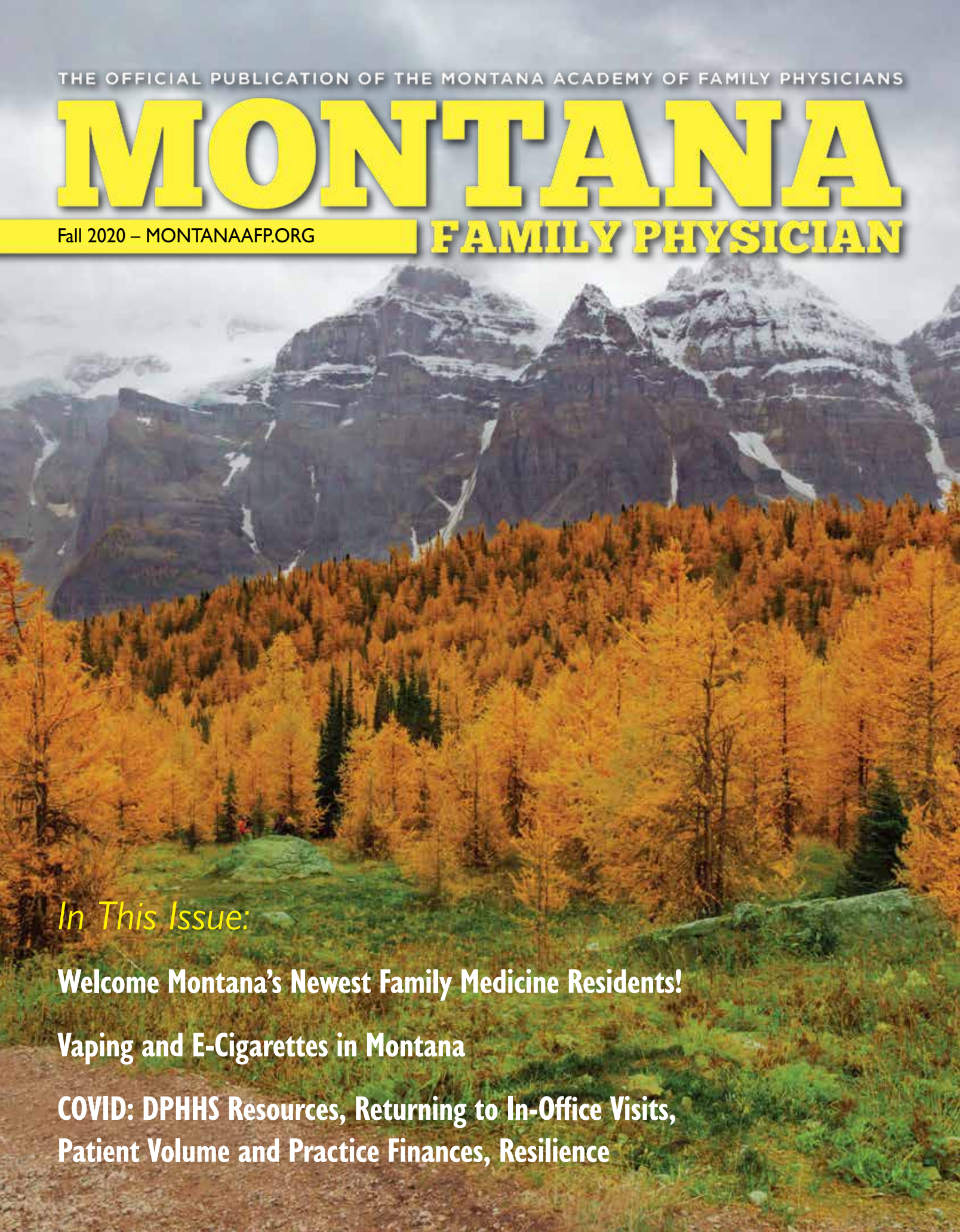
THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

Fall 2020 – MONTANAAFP.ORG



In This Issue:

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THE OFFICIAL PUBLICATION OF THE MONTANA ACADEMY OF FAMILY PHYSICIANS

MONTANA FAMILY PHYSICIAN

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EDITION 6

*The **Montana Family Physician** is printed, addressed, and mailed to every family physician, resident, and medical student in Montana as well as all 50 other state chapters.*

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Edition 6

MAFP President's Welcome

Jeremy Mitchell, DO

I hope this letter finds you well. We are in the midst of tough times in the world and in healthcare. I never expected to work in healthcare in the US in the middle of a pandemic.

I would like to mimic one of my favorite physician podcasters and start this letter by saying "Thank you!". Thank you for your service to your community and your patients. Thank you for being on the front lines. Thank you for your leadership. Your work is appreciated.

We are living in stressful times. There is a lot of medical uncertainty around COVID and social unrest. I would ask that you take some time to take care of yourself. Your job as a healer will be much more effective if you take care of yourself first. How are you getting energized and refreshed? I've had to set up boundaries on my time, even if it means saying no to good things. Are you eating healthy? Are you getting exercise? Are you spending time alone and in refreshing relationships? I am trying to focus on the basics including my faith, my family, and connecting with close friends. If you are stressed out by all that is going on, consider a media break for a time.

Finally, in your organization or clinic, continue your important work as leaders. Your staff and colleagues are watching you. The community is stressed and anxious about the future. Be graceful to those on your team. We are working through the uncertainty together. Practice gratitude.

Serenity Prayer by Reinhold Niebuhr

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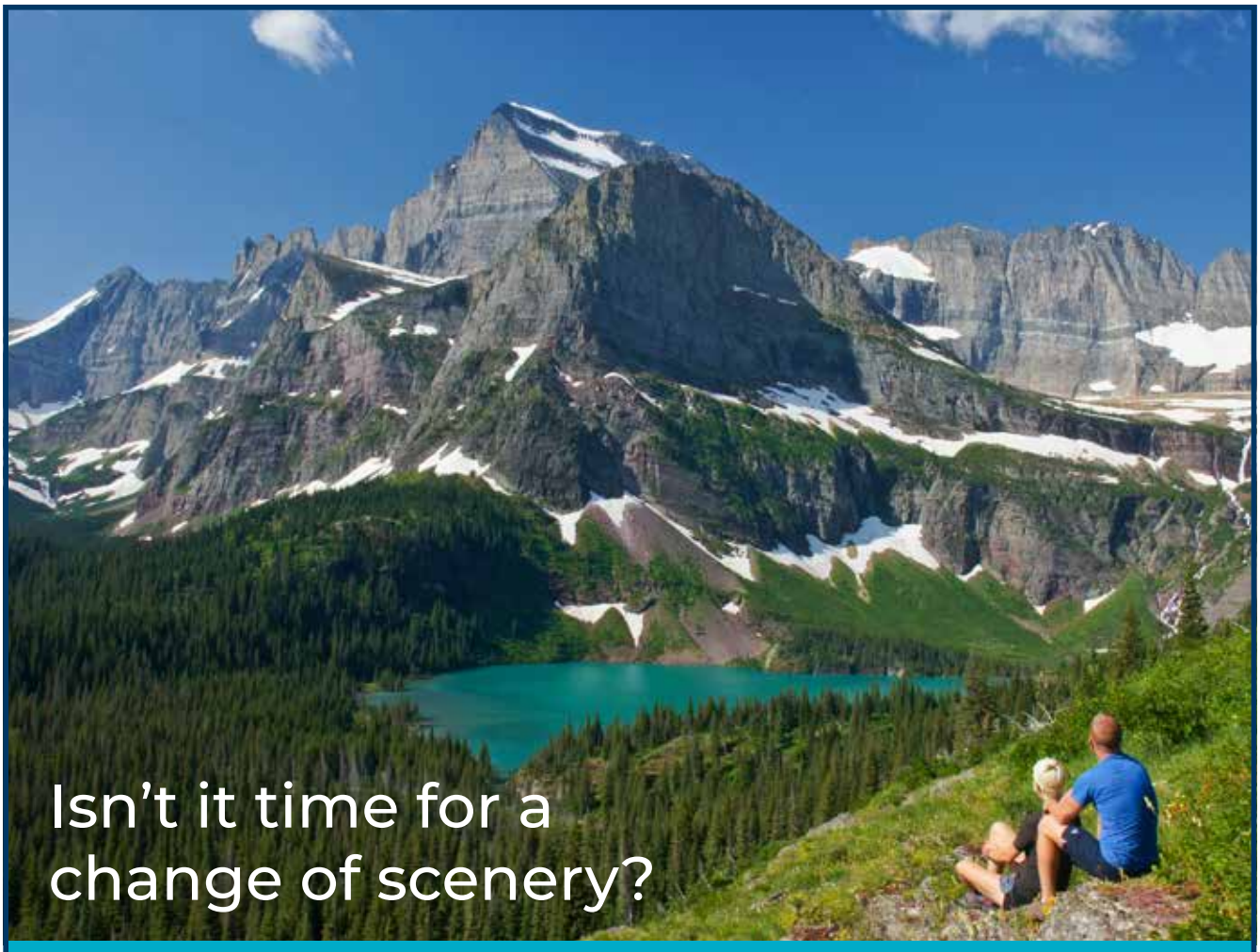

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KALISPELL REGIONAL HEALTHCARE

Montana Department of Health and Human Services COVID Resources

Information related to COVID-19 is constantly changing; use reliable sources when staying up-to-date locally, nationally and globally.

Montana specific COVID-19 disease information can be found at covid19.mt.gov. This website links you to the Department of Public Health and Human Services (DPHHS), the Joint Information Center (JIC), and the Montana newsroom.

The DPHHS COVID-19 website provides:

- map with demographic information for COVID-19 disease cases in Montana,
- COVID-19 testing information,
- symptoms of COVID-19 and what to do if you are sick,
- and much more.

The Joint Information Center website provides:

- links to directives and executive orders,
- disability resources,
- and contact information for the public to phone or email COVID-19 disease related questions.

The Montana Newsroom links to information from the Governor's Office and other State of Montana agency communications related to COVID-19 and much more.

The Centers for Disease Control and Prevention [cdc.gov] offers a variety of information useful for health care providers, including:

- information for health care professionals is detailed at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html [cdc.gov],
- infection control advice and resources: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html [cdc.gov], and
- training links for a variety of healthcare topics: https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html [cdc.gov].

Social media is also a great way to stay informed by following DPHHS on Facebook (@MTDPHHS), Public Health in the 406 (@Health406) and the Montana Disaster and Emergency Services (@MontanaDES) on Facebook, Twitter and Instagram. The national organizations listed also have social media pages you can follow.

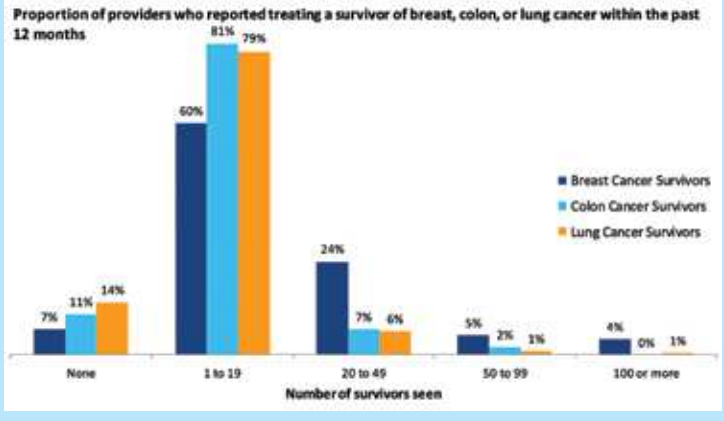
Help flatten the curve and take steps to protect yourself and others during this COVID-19 outbreak. Be sure to clean your hands often, avoid close contact, cover coughs and sneezes, and clean and disinfect surfaces.

Clinical Training on Cancer Survivor Care Coming to Montana

Montana Cancer Control Programs

As cancer mortality rates fall due to better treatment and effective screening, survivors of cancer are becoming more prevalent. The North American Association of Central Cancer Registries estimates that more than 30,000 people living in Montana in 2016 were diagnosed with cancer in the previous 10 years. A recent survey of primary care providers in Montana confirmed that most were currently treating a survivor of breast, lung, or colorectal cancer (Figure).

- 93% of providers reported treating at least one breast cancer survivor in the past year.
- 89% reported treating at least one colon cancer survivor in the past year.
- 86% reported treating at least one lung cancer survivor in the past year.



Yet many primary care providers have not received detailed training on the late and long-term effects of cancer and cancer treatment. Understanding the special needs of cancer survivors is essential to providing comprehensive care to these patients. The Montana Cancer Control Programs and Billings Clinic Project ECHO are working together to bring virtual clinical training on Rural Cancer Survivorship to Montana. There will be 6 monthly sessions starting in September 2020 covering a range of topics from managing co-morbidities in cancer survivors to fostering better communication between oncologists and primary care, and mental health concerns related to cancer survivorship. For more information about this training opportunity contact Kim Hart, Project ECHO Coordinator at Billings Clinic, 406-435-4556 or khart@billingsclinic.org.

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Building a Healthier Montana Takes a Team

With communication and education between prescribers and pharmacists, we can see Montana continue to lead the way in patient care and opioid dependence reduction.

This project is funded in whole by grant numbers 6 NU90TP921970-01 from the Centers for Disease Control and Prevention and/or 6H79TI080243-02M002 from the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services and from the Montana Department of Public Health and Human Services. The contents herein do not necessarily reflect the official views and policies of the U.S. Department of Health and Human Services or the Montana Department of Public Health and Human Services.

DREAMTEAM

Building a Healthier Montana Takes a Team

Be prepared to continue the conversation with your patients about the 7-day limit and what it means for them. Then, continue to work with pharmacists by checking the registry and prescribing accordingly.

7 DAY 1-2-3

1

PATIENT CHECK

Check the registry, is your patient opioid naïve?

2

PRESCRIBE ACCORDINGLY

Yes? Then the 7-day prescription period is required.

3

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Tell your patients, and work with pharmacists to see the new law through.

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Welcome Montana's Newest Family Medicine Residents!

FAMILY MEDICINE RESIDENCY OF WESTERN MONTANA
CLASS OF 2023

MISSOULA

Ben Merbler, DO
Kansas City University COM
Hometown: Canton, MI
Undergrad: Saginaw Valley State University
Interests: Ben's Interests include backpacking, camping, kayaking, golfing, music, guitar, reading novels, movies, exploring new places and traveling

Paige O'Connor, DO
Kansas City University COM
Hometown: Glendale, CA
Undergrad: Colorado College
Interests: Paige's interests include collecting vinyl records, independent films, skiing, backpacking, scuba diving, track and field, playing and watching soccer, solo traveling, cultural immersion, and living abroad (Grenada, Spain, Melbourne)

Jacqueline Ordemann, MD
Tufts University
Hometown: Groton, MA
Undergrad: Bates College - Lewiston
Interests: Jackie's interests include hiking, canoeing, kayaking, xc skiing, knitting, spinning yarn, farming, gardening, cooking, preserving food, and singing.

Stephen Reale, MD
Tufts University
Hometown: Melrose, MA
Undergrad: Dickinson College
Interests: Stephen's interests include composing music, playing music, singing, hiking, cooking, fitness, technology, and family.

Jonathan Rhea, DO
Des Moines University COM
Hometown: Houma, LA
Undergrad: University of Nevada at Reno
Interests: Johnathan's interests include backcountry skiing, mountain biking, backpacking, whitewater kayaking, photography, cooking, and gardening.

KALISPELL

Rachael Schmidt, MD
University of Nebraska
Hometown: Omaha, NE
Undergrad: University of Nebraska - Lincoln
Interests: Rachael's interests include dog obedience, fencing, climbing, D&D, photography, camping, and international travel.

Melanie Scott, DO
Pacific NW University COM
Hometown: Spokane, WA
Undergrad: Washington State University
Interests: Melanie's interests include hiking, running, traveling, baking, watching movies, and playing board games

KatiLyn Lucas, DO
Pacific NW University COM
Hometown: Richland, WA
Undergrad: Boise State University
Interests: Kati's interests include soccer, volleyball, hiking, rock climbing, skiing, mountain biking, piano, violin, flute, reading, running, traveling, and family game nights.

Taylor Simmons, MD
University of Washington - Idaho WWAMI
Hometown: Middleton, ID
Undergrad: Northwest Nazarene University
Interests: Taylor's interests include hiking, boating, skiing, crossfit (certified level 1 trainer), dogs (has a mini dachshund, Tucker Mowgli), and nutrition.

Barbara Steward, DO
Pacific NW University COM
Hometown: Plains, MT
Undergrad: University of Montana
Interests: Barbara's Interests include catching 20 lb steelhead, sappy romance novels, indulging her chocolate Habit, chasing sunsets, decompressing with family in the outdoors, river floating, personal training, board games, trying new restaurants, cats, and porch sitting.

MONTANA FAMILY MEDICINE RESIDENCY
CLASS OF 2023

BILLINGS

Douglas Burns, DO
Douglas comes to us from New York where he went to medical school at Touro College of Osteopathic Medicine. He has spent some time living in Bozeman, where he received his undergrad degree. He enjoys bookbinding, skiing, mountaineering, collaborative storytelling games, reading novels, and active commuting.

Ruth Chadwick, MD
Ruth's parents were missionaries so she grew up all over the world (Papua New Guinea, China, Florida, California) She's completing medical school at Ben-Gurion University of Negev. In her spare time, she loves to sew and has recently gotten into refashioning thrifted clothes and historical costuming; she also enjoys cooking and baking.

Amanda Fields, DO
Amanda is originally from Portland, Oregon, but has spent most of her life in Ellensburg in central Washington. She and her husband have 6 children between the two of them, along with their dog, Festus. She enjoys hiking, paddle boarding, and kayaking. Her family has frequently visited Montana and always try to stop for a day or two at a Montana hot springs before the final trek home, and a brewery or two. She comes to us from Pacific Northwest University of Osteopathic Medicine.

Christian Kilpatrick, DO
Christian is originally from Sheridan, WY, but also lived in Billings, MT, and has family in both places he calls home. He is finishing Medical School at the Arizona College of Osteopathic Medicine. When he has down time, he's a huge outdoors enthusiast - no matter if it's on water or up in the mountains. He also makes some time to pick up his guitar and have private jam sessions.

John Konow, MD
John was born and raised in Chicago, and is finishing up medical school in Australia, at the Univeristy of Queensland. John played volleyball through college and in his free time, likes to cook, color, and cuddle with his puppy – Bellatrix.

Cassie Lowry, MD
Cassie also comes to us from the Pacific Northwest University of Osteopathic Medicine in Yakima, WA. She is originally from Seattle. She likes to climb and ski and was even a roller skating champion.

Sam Matz, MD
Sam is an upcoming graduate of OHSU in Oregon. He was born in the bustling town of Cottage Grove Oregon, then moved to Weaverville, California where he grew up--3500 inhabitants still go on without so much as a stop-light. He trained as a nuclear reactor operator in the Navy, as well as a diver aboard a fast attack submarine. After the Navy, he worked in pharmaceutical manufacturing, and worked many nights to complete pre-medical requirements. His outside interests include mountain biking, kite surfing, hiking, and snowboarding, he is also interested in 3D printing.

Trent Taylor, MD
Trent will be joining us from the Medical College of Wisconsin. He and his family are excited to move to Montana, as his parents live in Helena, where his dad is Chief of Dental at the VA-Montana. His personal interests include podcasts, running, coffee, camping, hiking, skiing, climbing, board games, & video gaming. Joining him will be his wife and two daughters.

Lisa Baracker, DO
Lisa will be coming to us as a PGY2, she is finishing up a Family Medicine internship at the University of Michigan. She went to medical school at Touro University of Osteopathic Medicine in California. Before medicine, she worked at UC Hospital system in Denver, then as a Biochemist and Lab Manager in San Francisco Bay Area, became a doula (still is) and then Med School at 35! She brings her husband and family to Montana with her.

WWAMI Regional Update

WWAMI faculty and friends, just a little update on WWAMI teaching during the COVID pandemic. As you can understand these have been challenging times for all of us including our WWAMI medical students. The UWSOM removed students from clinical training opportunities on March 9th in the middle of clerkship experiences. This significantly disrupted both third- and fourth-year students.

- WWAMI fourth year students: Some graduating students were unable to complete either required or elective clerkships. Required clerkships in the fourth year include EM and Neurology. These fourth-year students completed a variety of online courses including "Pandemics" and "Clinical Educators" to name a few. Their graduation requirements were shortened in order to move them onto residency and internship. Match Day was virtual as was graduation.
- Dr. Laura Goodell a FM educator in Bozeman, who teaches in the Foundations Phase in Bozeman was chosen to deliver the virtual graduation address to the entire UWSOM graduating class of 2020. This is quite an honor and recognition of the outstanding medical educator that Dr. Goodell is for our Montana WWAMI students. To view her address, visit: https://www.youtube.com/watch?v=_2smjPZAPmw
- WWAMI third year students, transitioning to fourth year: These students were also allowed to take the online courses during their three months away from clinical training. Third year students were returned to clinical training on June 29th. Many in this group needed to complete a third-year clerkship before starting their fourth-year schedule. Career exploration including sub-I's were compressed into this summer-time period. As you can understand this created a large number of both third-year transitioning to fourth-year students and rising third-year students needing to be in required clerkships in both summer A and B. Thanks to the many preceptors who took on additional students during this time period.
- WWAMI rising third-year students: Because these rising third-year students had missed three of 12 months of their third year, the decision was made to shorten required clinical clerkships from six to four weeks for this current class. An added complexity. The UWSOM is still trying to navigate what happens with a medical student who is exposed to COVID or diagnosed with COVID and isolated/quarantined for 10-14 days during a four-week clerkship.
- WWAMI foundations phase students in Bozeman: students went to all online learning in March including the Foundations of clinical medicine course which is traditionally taught at the bedside with lots of hands on experience. The Primary Care Preceptorship experience, an in-office experience of clinical learning, was also put on hold. Foundations phase students participated in RUOP and research experiences this summer.

Montana WWAMI would like to thank the many clinical faculty who have continued to teach our WWAMI students during this stressful and unprecedented pandemic time. I know in my clinic in Whitefish, which is a FM clerkship teaching site, my partners and I have enjoyed having students back in our clinic and experiencing medicine during this COVID pandemic. It is imperative that we keep these classes of students on track to graduate on time as they will be needed to join the residency learning experience in 2021 and 2022. Thank you again for your dedication to teaching our students.

Jay S. Erickson M.D.
Assistant Dean for Regional Affairs
Assistant Clinical Dean, WWAMI Montana
Clinical Professor
University of Washington School of Medicine

A Wolf in Sheep's Clothing:

Vaping and E-cigarettes in Montana

Lauren K. Turich, MPH, MS, (MS-IV) and Daniel Bester (MS-IV)

The authors are fourth-year medical students rotating in Montana from Saint James School of Medicine. They have been active previously with the Illinois Academy of Family Physicians. Lauren is pursuing a family medicine residency. Her professional interests include utilizing her MPH to develop public health incentives for population health and addressing maternal care deserts as a full-spectrum family medicine physician. Daniel is also pursuing a match into family medicine this upcoming year. He is interested in rural health and exploring the many roles a family physician can fill.

Vaping and E-cigarettes in Montana

E-cigarettes have become the most commonly used tobacco product among Montana teens. 30% of Montana high school students use e-cigarettes and 58% have at least tried an e-cigarette.[1] These statistics are especially alarming because the use of e-cigarettes and vaping products lead to traditional cigarette smoking.[2] The probability of cigarette smoking initiation increases from 7% to 23% for adolescent and young adults who had ever smoked an e-cigarette.[3]

American middle and high school students reported the following as the major motives for initiating use of e-cigarettes and vaping products: 39% of "ever" users admitted they started using them because a family member or friend used them;[4] 31% reported they were initially attracted to the variety of flavors, like mint, candy, fruit, or chocolate;[5] and, 17% perceived these products as less harmful than other forms of tobacco products, like cigarettes.[6]

What are e-cigarette and vaping products?

E-cigarette and vaping products come in a wide variety of forms and appearances. Some products have even been intentionally disguised to look like a USB flash drive.

These products contain highly addictive Nicotine that has been shown to harm brain development in adolescents.[7]

It is estimated that one refillable JUUL device is the equivalent of 20 cigarettes. Alarmingly, 63% JUUL users between the ages of 15-24 were unaware that these devices contained any nicotine and thought they simply contained flavoring.[8]

These products can be modified and sold to users so that other products, like CBD and THC, can also be vaped. In addition to THC, these modified products have been found to contain Vitamin E acetate, a thickening agent.[9] Vitamin E acetate has been identified in the bronchoalveolar lavage fluid samples of patients diagnosed with EVALI, or e-cigarette or vaping product use associated lung injury.[10] EVALI is an inflammatory reaction in the lungs in response to inhaled substances. These unregulated and modified e-cigarette and vaping products increase the risk for EVALI among users.[11]

As of February 18, 2020, the Montana Department of Public Health and Human Services confirmed 8 cases and 1 death from EVALI. The CDC recommends that e-cigarette users should not use unregulated e-cigarette products or modify their e-cigarettes in any way.[12]

Screening for E-cigarette Use and Vaping

The USPSTF screening recommendation summary can be found on Table 1. The CDC recommends physicians screen all adult and adolescent patients about their use of e-cigarette, or vaping, products in an empathetic, nonjudgmental manner. The CDC also encourages physicians to ask about respiratory, gastrointestinal, or constitutional symptoms when a patient admits to using e-cigarette and vaping products to assess their risk for EVALI.

The AAFP endorses the "Ask and Act" approach to aiding in tobacco cessation. "Ask and Act" was developed based on recommendations set forth by the U.S. Public Health Service and aims to encourage all family physicians to "ask" patients about tobacco use and "act" to help them quit. For more information about the "Ask and Act" program and to access their resources, go to (www.askandact.org).

Some e-cigarettes are made to look like regular cigarettes, cigars, or pipes. Some resemble pens, USB sticks, and other everyday items.

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continued from page 15>

E-cigarettes and Vaping as a Tobacco Cessation Method

The FDA has not approved e-cigarettes and vaping products as safe and effective forms of tobacco cessation. When adults have attempted to use e-cigarettes or vaping products as a form of tobacco cessation, they simply ended up using traditional cigarettes and e-cigarettes or other vaping products simultaneously.[13]

The USPSTF recommends the use of evidence-based behavioral interventions and pharmacotherapy as effective forms of cessation methods for adults 18 years and older. The AAFP reaffirms that advice from health care professionals can more than double smoking cessation success rates.[14]

Population	Recommendation	Grade
Adults who are not pregnant	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.	A
Pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A
Pregnant women	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women.	I
All adults, including pregnant women	The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety (previously stated).	I

Table 1

Recent Changes in State Laws

In October 2019, Governor Bullock signed an emergency ban on all flavored e-cigarettes, nicotine, THC, and CBD vaping products, as a response to the public health crisis set forth from these products. This emergency ban expired in April 2020.

In July 2020, the Department of Public Health and Human Services of Montana hosted a virtual public hearing about the prohibition of selling, offering for sale, marketing, advertising, or otherwise distributing flavored electronic smoking

devices to Montanans. The Montana Academy of Family Physicians submitted a letter of support for the ban, particularly focused on the risks of flavored vaping products for Montana's youth. The department intends for the rules of the legislation to be effective on their date of adoption.

Recent Changes in Federal Laws

In December 2019, the President signed legislation that raised the minimum age of sale of tobacco products from 18 to 21. Under this legislation, "tobacco products" include e-cigarettes, cigars, and traditional cigarettes.

Recommendations

As Montana's family physicians, we must continue to use screening techniques to identify those at risk for e-cigarette use and vaping and provide evidence-based cessation behavioral interventions and pharmacotherapies. We must encourage the passing of state laws that ban flavored tobacco products throughout the state, permanently; and, encourage all localities in Montana to prohibit the use of e-cigarettes in workplaces, indoor public places, parks, and other community venues.

Endnotes

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Returning to In-Office Patient Visits Welcome to the New Normal

Most of us have never experienced a pandemic before nor have we been faced with the potential of contracting a disease that can threaten our lives. You all know, as medical professionals, you are anxious to return to work, open your offices and to provide your patients with the healthcare services they need, want and trust you to deliver. But how can you open your offices again and convince your patients it's safe to come in for their appointments?

First and most importantly, it is imperative to realize that 30% of COVID-19 carriers are asymptomatic, and 44% of transmissions occur from asymptomatic or pre-symptomatic people. And 77% of individual work spaces do not provide 6'-0" distances between employees as recommended by CDC guidelines. As with most organizations, you will probably be looking to make smart investments to help reduce the risk of disease transmission. So let's examine your office and introduce some elements that will conform to post-COVID-19 safety measures.

1. Establish one entrance and, where possible, a separate exit.
2. Where deemed necessary, lay down a fresh construction-type "sticky mat" every day to remove from visitors' shoes any malicious elements that may be introduced into the office.
3. Create one-way traffic patterns for visitors throughout the suite, where possible, to avoid face-to-face contact while traveling the corridors. This can be done with arrow decals on the floor, whether hard surface or carpet.
4. Where unsure how to assure a safe work environment, engage a space planner/designer to assist with these modifications.
5. Use anti-microbial chemicals to wipe down all surfaces that will come into contact with providers, staff and patients. These chemicals - most commonly alcohol, chlorine bleach, hydrogen peroxide – can be used on many non-porous surfaces. For fabrics or other porous surfaces, refer to https://www.cdc.gov/infectioncontrol/guidelines/disinfection/disinfection-methods/chemical.html
6. Position hand-sanitizer stations on tabletops, mounted on walls or freestanding units at strategic locations for everyone's use. Alternately, set up sanitizing wipes stations with lined trash cans for disposal.
7. Post a list of rules at the sign-in counter so that every employee and visitor knows what you expect of them. The CDC has printable posters and notices readily available for posting in the workplace related to hand hygiene, respiratory hygiene and cough etiquette.
8. At the check-in and check-out windows, install Plexiglas barriers with low openings so that papers and payments can be passed back and forth. Use decals on the floor to show people social distance spacing while waiting.
9. Remove excess chairs from the waiting room or tape chairs off to "de-densify" and discourage non-distant seating. Remove magazines from the waiting room and normally-shared items that were kept at a nourishment station. Bottled water can remain.
10. For employee work areas, install hard-surface opaque or Plexiglas dividers between workstations that are 54" high and modify the distance between employees to be 6'-0".
11. For those who have direct contact with patients, wear masks and other approved personal protective equipment at all times.
12. Conduct sales rep visits virtually, receive samples by delivery to a designated entrance.
13. Order lunches for pick-up or delivery to a specific entrance. Set rules for storing food in the break room refrigerator that keep all employees safe and discourage sharing food and condiments.
14. Use hands-free trash cans with foot pedals for hands-free use. Have often-used doors fitted with foot pedal openers for efficient hands-free usage.
15. Set up a schedule for emptying exam room disposables throughout the day. Where possible, set aside a closet for storage of disposed medical and non-medical materials from exam rooms.
16. Convene a web staff meeting to outline the rules of working in the office, and have everyone sign a compliance document, agreeing to follow these rules. Post these

guidelines in visible employee areas in the office.

17. Assure everyone that supporting the Safety Rules Plan is best for everyone; make it easy to follow. Fine leadership is key. Lead by example.

For safest employee compliance, consider implementing the following procedures:

Take all employee's temperatures upon entering the office suite. Require any employee with symptoms or fever to remain at home for 14 days quarantine as set forth by the CDC. Medical groups can request medical certifications before an employee returns to work. As a practical matter, however, doctors and other health care professionals may be too busy during and immediately after a pandemic outbreak to provide fitness-for-duty documentation. Therefore, new approaches may be necessary, such as reliance on local clinics to provide a form, a stamp, or an e-mail to certify that an individual tests negative for COVID-19. Additionally, medical groups may impose other reasonable requirements to help ensure the employee is not infected (e.g., by requiring that he/she attest to being symptom free during the incubation period or, where the employee was symptomatic, that they be symptom-free for at least a determined number of days without medication, and/or requiring that he/she test fever-free before returning to work).

Where possible, establish alternating work days or hour-shifts to limit occupancy. Allow those whose jobs do not require them to be in the office to work from home. If necessary, arrange for new remote connectivity so that phone/scheduling personnel can work from home while still connected to the computer system safely. This may require an additional computer security system.

Make handwashing in the break room, bathrooms and office essential. Include signage to instruct wiping down equipment before and after use in all areas. Remove any non-essential seating. Discourage workers from sharing chairs and equipment. Encourage wiping down of all chair arms, desk surfaces, keyboards, mice, phones, headsets, copiers, door levers, toilet room fixtures and break room equipment. Set up a schedule for these cleanings, posted with required initials upon completion.

Provide a designated holding space/de-casing area for incoming parcels. Leave doors open in areas that do not require privacy to reduce door lever contact. Where possible, have air ducts cleaned, change out HVAC filters often and increase the rate of air exchange.

Establish a formal & monitored, cleaning and disinfecting schedule for all high traffic areas. Determine what needs daily, weekly cleaning and disinfecting. For areas requiring monthly and 90-day disinfecting, set up a schedule with a formal commercial cleaning company.

Now let's walk through a typical patient visit.

Send an email blast to all patients that, YES, WE'RE OPEN and have taken these necessary steps to assure their safety and comfort. Offer the list. If you schedule appointments by phone, see if telemedicine is appropriate - to control the tide of in-office visits. If the patient must be seen in the office, let all patients know ahead of time that there are rules they must follow while in the office, and follow up by sending these out again via email.

When they arrive at the office:

Advise them that they should call to advise that they have arrived. They should remain in their cars or outside the suite or building until invited in by phone. That way, you can let them know when the waiting room has only the required number of patients so they can remain socially distant when they're allowed to enter.

Unless this is a facility designated to admit sick patients, advise that they will not be admitted if they have a fever or other symptoms of illness. Patients only will be admitted – no companions or family members. Exceptions can be made for child patients. Patients must wear masks – no exceptions. Take their temperature when they arrive; direct them to the sanitizing station to wash their hands. Have them check-in and take them to an exam room if waiting is not required.

Make the office and waiting room friendly while making it safe.

Add biophilia – potted live plants or live "green walls" to add an element of tranquility people normally feel in the presence of outdoor greenery. Add pleasant figurative artwork to give people relaxing images to look at while waiting. Remember to adhere to all ADA and HIPAA compliant guidelines for the comfort of all patients.

When patients are ready to leave the office:

Ask them to sanitize their hands once more before leaving the exam room (which protects the check-out station and exit door lever). Direct them to the check-out window. Have someone be responsible to thoroughly wipe down the exam room and dispose of all disposables into a closed receptacle or closet.

Open your offices after you have done the required preparatory modifications to deal with the post-COVID-19 era. Do it safely, wisely and enjoy having your employees and patients return for office visits.

Feel free to call or email me. We'll be happy to retrofit your office with COVID-19 prevention design practices and products to create a safer environment for your employees and patients.

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Recovering Patient Volume and Practice Finances in the Wake of COVID-19: 12 Tips

Nationally, patient volume has dropped 60% (www.medscape.com) since the start of the pandemic and is now rebounding, either gradually or rapidly depending on local circumstances. However, practices are unlikely to return to normal volumes for some time as patients continue to avoid the office and as offices continue to keep high-risk patients at home and treat them via telehealth. These changes in patient volume have had drastic effects on practice finances, with one report noting that practice revenues have declined 55% (www.medscape.com).

As the lead family doctor in a small group practice in northern California and as a local medical director for Aledade (an organization that supports independent practices in building physician-led ACOs), I've seen a variety of responses from practices trying to recover their patient volume and their finances in the wake of COVID-19. Based on what we have learned in our area, I have gathered some tips that may be useful to other practices as well.

1. Continue to evaluate your mix of visits — in-office vs. virtual — as you seek to increase patient volume to normal levels while being responsive to the conditions in your area and the needs of your patient population. Infectivity and surges appear to have surprised each community in the news, so be prepared for local changes and patient ebbs and flows.
2. Make sure you have a clear process for deciding which visits should take place via telehealth and which can take place in the office. Practices have different philosophies on this. We are converting all visits to telehealth unless they involve a procedure, under 5's and middle school children for well-child checks and for immunizations, some teens, women whose pap smears are overdue or who have had an abnormal pap smear, and those whose diagnosis we were unable to make without a more detailed exam. My day currently averages 12 telehealth visits, three or four office visits, and two or three visits out of people's cars (usually patients who lack devices or just want to be seen in person without needing a detailed exam). We feel this is the safest approach until we have better insight into how to avoid asymptomatic and presymptomatic transmission. Additionally, it's tough to get an exam room turned over safely without letting it air out for some time, cleaning after each patient. We are aiming for a maximum of two patients per hour in our two small offices with five to six exam rooms, until we have a better understanding or approach to safety. For patients who do come to the office, we have trained our staff to assume all patients are positive and to use appropriate masking and personal protective equipment (PPE). In this way, we hope to avoid constant changes to policy if there are local surges, and to avoid inconsistency and confusion for our patients.
3. Reach out to patients. Demand can be influenced by patient engagement and improved with a strong front-office operation. Contact patients by risk category, starting with those who are high risk (e.g., those with chronic conditions leading to immune suppression), and let them know about the availability of telehealth or other visit options so they can have a plan of care during this crisis. You should also reach out to patients who have had cancellations over the past three months to let them know about their visit options. Even for preventive care, you can partner with patients on decisions to postpone or proceed with routine physicals or other preventive services.
4. Develop new messages for your web site, phone system, social media, or

office signage to communicate your intention to continue providing care and explain the available visit options.

5. Consider adjusting your staffing levels. These are difficult decisions, but some options include furloughing nonessential staff, encouraging staff to take rotating vacation days or perhaps unpaid days off, and not replacing staff who chose to stay home in the early stages of the pandemic due to health or other concerns such as childcare needs. Interestingly, we have experienced staff loss and are finding replacement difficult, perhaps because staff who were furloughed are receiving enhanced unemployment payments in the short term.
6. Closely monitor financial benchmarks, from accounts receivables to payer mix. Your practice should have a spreadsheet that allows you to quickly see key parameters such as payments and charges by clinician. You need to be monitoring whether revenue is down and by how much so you can take action.
7. Educate yourself on new billing codes and rules, and ensure billers are using and following them. Make sure your staff are looking at insurers' Explanation of Benefits forms for denials and are rebilling, particularly for early telehealth codes that were denied. For example, Medicare changed its recommendations for the telehealth modifier and place of service codes, allowing telehealth video visits to be billed as in office and providing parity in payments. But this was a few weeks after the onset of sheltering orders in many states, and in some cases practices needed to rebill. The same is true for telephone care codes.
8. Have your front-desk staff pay closer attention than usual to insurance changes since patients may have lost jobs. Additionally, some insurance companies have agreed to waive co-pays or coinsurance in the short-term for telehealth visits. Communicating this to patients may give them an incentive to schedule an appointment. Just make sure your staff understands which insurance companies are offering this and which aren't so that co-pays don't have to be collected after the fact — always an inefficient and time-consuming task. Also note that any viral infection in the current environment should be documented as possible COVID-19 because, while there is not a way to code for this besides by symptoms, many insurers have stated they will cover all or part of the cost of COVID-19. For example, Medicare has waived cost-sharing for visits that result in the order or administration of the COVID-19 test or involve the evaluation of an individual to determine the need for such a test; physicians should use modifier -CS to identify these services.
9. Review current obligations and fixed expenses. Are there any expenses you can cut? If you are unable to downsize in any way, at least create a monthly budget and try to stay within it for new expenses. Don't hesitate to negotiate forgiveness for a month or two from landlords, vendors, etc.
10. Pay attention to inventory, and keep it lean where possible. You don't want to have too much cash tied up in supplies right now. For example, we used to keep a month's supply of vaccines but now keep just a week's supply while prioritizing vaccinations and doing outreach to keep the children in our practice up to date. We are keeping other supplies lower because of fewer procedures and in-office visits. An exception is PPE. PPE costs are unpredictable right now but tend to be high even if there is availability, so we have to account for this.
11. Consider unforeseen expenses, such as devices for telehealth. Because most offices had to embrace telehealth quickly, they don't have an ideal setup in place. For example, our office is making do with a few donated (repurposed from personal use) old tablets or iPads, and some physicians are using personal smartphones to see patients for the visual component of the telehealth visit. We have also converted old smartphones with new prepaid three-month SIM cards to give us a throwaway number to use for FaceTime and Skype for patients who cannot manage the HIPAA-compliant televisit technology. Since the relaxed HIPAA requirements for telehealth have an unclear sunset date, prepaying a few months at a time ($15 a month) has been a cost-effective solution. While $200 million in federal FCC funding (www.fcc.gov) has been made available to community clinics for device upgrades, no similar support is available for independent practices.
12. Consider all available options for financial assistance. Physicians who see Medicare patients should have received two stimulus payments (those who do not see Medicare patients were eligible to receive only the second stimulus amount), but many have found the combined total to be inadequate — in the range of one payroll cycle or less. The federal Payment Protection Program is another vehicle for payroll support for medical practices, although some businesses have had difficulty obtaining these loans. Medicare and some other payers have offered cash advances, which provide short-term relief but reduce future cash flow during the repayment period. For many practices this period will begin in August, leading to financial difficulties if they do not adhere to a tight budget. Practices that do not already have a relationship with their banker and a credit line in place should be looking at doing so now.

What practices need going forward

Family medicine and other primary care specialties have been undervalued and under reimbursed for years in this country, and our current visit-based, fee-for-service payment system does not provide steady financial support to care for a patient population. The current strain will require both skilled navigation by practice owners and managers, and strong advocacy from the organizations that represent us. In the process of struggling to pay expenses and do the work, many practices may fold unless payers make rapid shifts toward value-based care.

Meeting Adversity with Resilience: A Physician's Disaster Recovery Plan

Whether it's a global pandemic, the loss of a loved one, a devastating clinical outcome, divorce, or other major life stressor, everyone experiences some form of adversity during their lives. It's really not a matter of if, but when. How you manage adversity impacts not only your well-being and personal relationships, it affects your capacity to perform professionally, and may even have organizational implications if you're in a position of formal leadership authority.

Even when you're not in a season of adversity, others around you might be. Thus, it's important to promote resilience, lead by example, and influence structural and organizational design so employees and colleagues around you can thrive. Leaders who take a page from their organization's playbook and create a personal disaster recovery plan will be more resilient and better able to minimize the effects of adversity.

The Role of Well-Being

Your resilience is heavily dependent on your well-being, which can be broken down into five elements: purpose, social, financial, community and physical. According to Gallup and Healthways, only 7% of adults are thriving in all five areas. These individuals, however, miss 70% fewer workdays per year, are 45% more adaptable to change, and are 59 percent less likely to job hunt. We'd all be better leaders — better people — if we thrived in these five areas. To improve resilience, it's prudent to assess your state of well-being.

First, consider your emotional intelligence — the sum of your self-awareness, self-management, social awareness and relationship management. As a leader, you likely have a high degree of emotional intelligence; but, it's important to continue strengthening these skills to help yourself and others through adversity. Not unlike muscle strength, emotional intelligence increases with intentional practice and atrophies when neglected.

Next, consider growth opportunities. Whether personal or professional in nature, growth helps you stay nimble and adapt during change. Carve out protected time to reflect, assess your goals, and invest in developmental opportunities and formative relationships whenever possible.

Don't forget to assess your self-care habits. Being healthy in mind, body and spirit is essential, particularly amid adversity. This means: eating right, exercising, sleeping, and taking care of yourself — advice you certainly already know, but might no be practicing.

Then, think about your mindfulness, which involves periodically turning off outside stimuli to clear your mind. Meditation, yoga, prayer and other forms of mindfulness are known to calm, heal and provide other neurological benefits.

Also, take a look at your community. Meaningful social connections are key to your well-being and vital for navigating adversity. Community includes peers, mentors and sponsors, friends, mentees, A-players within your organization, national thought leaders and individuals outside your profession.

Finally, embrace adversity. These times can be tremendous opportunities for growth. By embracing adversity — intentionally and intelligently — you will become a better leader.

Developing Your Disaster Recovery Plan

If you are feeling anemic in one or more of these areas because of a current adversity, now is the time to enhance your well-being and improve your resilience. Consider integrating these strategies, tools and resources in your disaster recovery plan:

Professional Counseling.

Loved ones are important allies but professional counselors are experts and leverage best practices. It's also their job, so you'll have their undivided attention. You are not weak for seeking the assistance of an expert advisor in a season of adversity. In fact, it's a wise investment to do so.

Community.

You likely have a strong community already, but strengthening it can't hurt. Receiving guidance and support from people who know you and understand or empathize with your struggle is invaluable. In times of adversity, fatigue or overwhelm can tempt you to isolate. Resist this urge! Now is the time to seek and accept the support of those around you.

Transparency.

Being transparent is important for your well-being. Let people know you're human and working through adversity. Others may have experienced similar adversity and may be able to help, or you may be able to help someone down the road.

Reading.

Learn about others' experiences in biographies and memoirs. Discover coping techniques in self-help. For inspiration and strength, turn to religious or spiritual works. And to escape, read fiction.

Finding a Creative Outlet.

In medicine, you primarily use your "left brain," so exercising the "right brain" can be cathartic. "Right brain" activities include writing, performing arts and music, fine arts, crafting, and woodworking.

Balancing Your Mind,

Body and Spirit. Stress affects our bodies and minds. Being a healthy individual when disaster hits will help you remain healthy while you're recovering.

Taking Time to Cope.

In times of adversity, some of us bury ourselves in work when we really need to take time to cope. This may mean taking time off, taking a short break, or sometimes just leaving work at work can help.

Major life stressors can knock you off your feet, sometimes literally, and affect you for weeks, months — even years. By improving your well-being and creating your own disaster recovery plan, you'll be a more resilient leader when adversity strikes.

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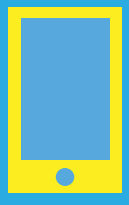
We may be keeping our distance,
but we are in this together.

Stay Calm.



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