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All material for publication, including advertisements, must reach the Society office no later than the 5th (business) day of the month preceding the date of issue, e.g. December 5 for the January/February issue. Thank you.

Macomb County Health Department and Community Partners Launch County-Wide Health Survey

HEALTHY MACOMB, A PARTNERSHIP BETWEEN THE MACOMB COUNTY HEALTH DEPARTMENT (MCHD) AND OVER 20 ORGANIZATIONS AND AGENCIES IN MACOMB COUNTY, HAS LAUNCHED A COUNTY-WIDE SURVEY TO HEAR THE NEEDS AND PRIORITIES OF COMMUNITY MEMBERS. The Macomb County Community Health Survey will help MCHD and its community partners identify and address the most important health concerns in the county.

Everyone who lives, works, and plays in Macomb County is encouraged to complete the survey at https://www.surveygizmo.com/s3/5698762/Macomb-County-Community-Health-Survey. The survey takes 5-10 minutes to complete and is available in English, Spanish, and Arabic. By taking the survey, community members throughout Macomb County have the opportunity to tell county organizations how to make Macomb County a healthier place for their families and their communities.

The COVID-19 pandemic has only increased the importance of hearing from community members in Macomb County about their health needs. Survey questions ask respondents how they have been impacted by the COVID-19 pandemic in addition to other important health issues.

The Macomb County Community Health Survey is part of the 2020 Community Health Assessment (CHA), a process that aims to understand the greater health and well-being of Macomb County. The first CHA in Macomb County was completed in 2016. Healthy Macomb organizations will continue to gather community member input in the coming months, with the goal of completing the CHA in early 2021.

To learn more about Healthy Macomb, the CHA process, or how community member input is used to improve the health and well-being of Macomb County, you can visit https://cha.macombgov.org/Cha-Home.

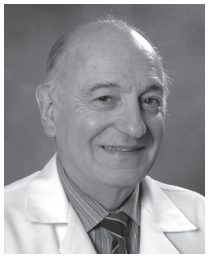
About the Macomb County Health Department

In partnership with the communities we serve, the mission of the Macomb County Health Department is to protect the health and well-being of all who live, work, and play in Macomb County. We pursue our mission by providing a wide range of programs and services that are delivered by Environmental Health Services, Family Health Services, Community Health Planning and Promotion, and our Disease Prevention and Control program.

For more information, visit: https://health.macombgov.org/Health-Home.

Healthy Macomb

HEALTHY MICHIGAN PLAN HEALTH RISK ASSESSMENT PHYSICIAN EDUCATION AND OUTREACH MATERIALS



By: Adrian J. Christie, MD
MSMS Region 2
District Director

The Michigan Department of Health and Human Services has developed three short videos for clinicians on the Healthy Michigan Plan (HMP) Health Risk Assessment (HRA) and the Healthy Behaviors Incentives Program. Clinicians play an important role in the HMP HRA and Healthy Behaviors Incentive Program and these videos have been developed to provide tips and best practices to primary care offices. These videos also highlight how to complete the HRA online to facilitate in-person or telehealth visits. For more information, please visit the Healthy Michigan Plan website at www.michigan.gov/healthymichiganplan

HEALTHY MICHIGAN PLAN | COMPLETING The Health Risk Assessment

Completing the Health Risk Assessment: This video is an introduction to the HMP HRA for clinicians and a step-by-step guide to completing the HRA, including all four sections and the primary care provider attestation.

Submitting the Health Risk Assessment: This video provides some suggestions for integrating the HMP HRA into clinic workflow and for submitting the form once it is completed.

Overview Healthy Behaviors Incentive Program: This video is an overview of the Healthy Michigan Plan Healthy Behaviors Incentive Program, which includes the HMP HRA, Preventive Services, and Wellness Programs.

These videos were produced in partnership with Michigan State University - Institute for Health Policy, Michigan Public Health Institute, and the Michigan State Medical Society, with support from the Michigan Health Endowment Fund.

MSMS SUPPORTS THE AMA STATEMENT ON ONGOING ATTACKS ON PHYSICIANS TREATING COVID PATIENTS

"In recent weeks, a series of deeply troubling COVID-19-related charges have been leveled against the medical community by the President of the United States. These baseless allegations are harmful and misleading to the public. As a community of Michigan physicians, we stand together with our colleagues at the American Medical Association in voicing our support for physicians and our fellow health care team members risking their lives so that the life of someone's spouse, parent, sibling, child, or friend may be saved. As our state and nation continue to do battle with this virus, it's important for all of us to follow the science and put safety first," S. Bobby Mukkamala, MD, MSMS President.

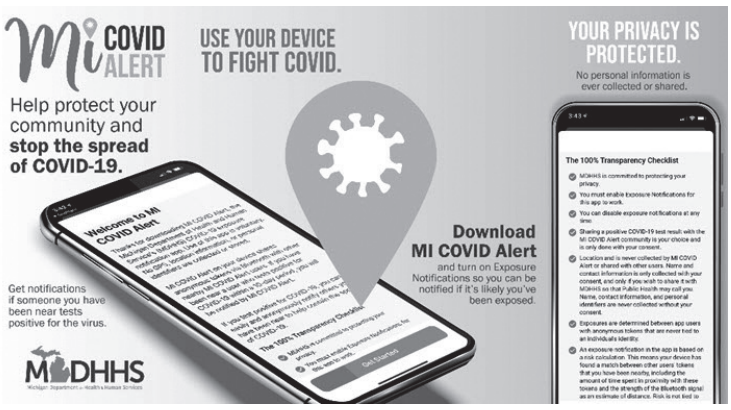
"Throughout this pandemic, physicians, nurses, and frontline health care workers have risked their health, their safety and their lives to treat their patients and defeat a deadly virus. They did it because duty called and because of the sacred oath they took. The suggestion that doctors - in the midst of a public health crisis - are overcounting COVID-19 patients or lying to line their pockets is a malicious, outrageous, and completely misguided charge. COVID-19 cases are at record highs today. Rather than attacking us and lobbing baseless charges at physicians, our leaders should be following the science and urging adherence to the public health steps we know work - wearing a mask, washing hands and practicing physical distancing," Susan R. Bailey, MD, President, American Medical Association.

MI COVID ALERT APP LAUNCHES STATEWIDE

Michiganders are encouraged to download the MI COVID Alert phone application from the Apple or Google app stores. MI COVID Alert is a free, easy-to-use, and anonymous app to help you stay informed and protect yourself or others from spreading COVID-19.

Downloading the app provides protection going forward if you become exposed to someone who tests positive. The app uses low energy Bluetooth technology to detect phones with the app near you and send alerts for potential exposures. If someone tests positive for COVID-19, a local health department or the Michigan Department of Health and Human Services will provide them with a code to enter into the app. If you have been in close contact (within 6 feet for at least 15 minutes) with someone who has COVID-19, you will receive a push notification to your mobile phone through the app.

Encourage your employees, members, friends and family to download the app today in the Apple or Google app stores.



IMMINENT CYBERCRIME THREAT TO US HEALTH CARE PROVIDERS

The Federal Bureau of Investigation (FBI) and two federal agencies are warning of an "imminent cybercrime threat" to US hospitals and health care providers, noting that several hospitals across the country have already been hit. In a joint advisory, the Cybersecurity and Infrastructure Security Agency (CISA), FBI and the U.S. Department of Health and Human Services (HHS) said they have "credible information" that cybercriminals are taking new aim at health care providers and public health agencies as the COVID-19 pandemic reaches new heights. "Malicious cyber actors" may soon be planning to "infect systems with Ryuk ransomware for financial gain" on a scale not yet seen across the American healthcare system. Hospitals, physician practices, and public health organizations should take "timely and reasonable precautions to protect their networks from these threats." Malware targeting techniques often lead to "ransomware attacks, data theft, and the disruption of healthcare services." The agencies recommend several mitigation steps and best practices for health care entities to take to reduce their risk, including the following:

- Patch operating systems, software, and firmware as soon as manufacturers release updates.
- Regularly change passwords to network systems and accounts and avoid reusing passwords for different accounts.
- Use multi-factor authentication where possible.
- Disable unused remote access/Remote Desktop Protocol (RDP) ports and monitor remote access/RDP logs.
- Identify critical assets; create backups of these systems and house the backups offline from the network.
- Set antivirus and anti-malware solutions to automatically update; conduct regular scans.

The American Medical Association (AMA) and the American Hospital Association (AHA) have created two resources to help physicians and hospitals guard against cyber threats. Those resources and additional cyber security information can be found at the AMA's cybersecurity webpage.

BeAWARE AND HELP SAVE LIVES

In Michigan, 7.23 million opioid prescriptions were dispensed in 2019 versus 10.8 million in 2015 - a drop of almost 15 percent. Unfortunately, deaths related to opioid overdose continue to increase, with the lives of 2,036 Michiganders lost in 2018. To help reverse this trend and save lives, physicians and other prescribers are encouraged to consider co-prescribing naloxone to their patients at-risk of overdose when clinically appropriate to do so. Even just having the conversation will help to educate people about this life-saving medication and how to prevent, identify, and respond to an overdose. For more information about naloxone and related facts, please download MSMS's Quick Facts document and visit http://MSMS.org/BeAWARE.

MSMS BOARD OF DIRECTORS MEET, DISCUSS HEALTH CAN'T WAIT AND PRIOR AUTHORIZATION

During the October meeting of the Michigan State Medical Society (MSMS) Board of Directors, the Board discussed the latest information in regards to Health Can't Wait, a coalition of patients, physicians, and health care providers dedicated to putting Michigan patients first and ending delays in patients' access to health care, and had a presentation from the Michigan Hospital Medicine Safety Consortium.

Prior Authorization

Senate Bill 612, introduced by Senator VanderWall, is the bill to reform prior authorization and step therapy developed and advocated by MSMS and the Health Can't Wait Coalition. The bill was substituted and reported overwhelmingly (8 yeas - 0 nays - 2 passes) out of the Senate Committee on Health Policy and Human Services on September 24.

The substitute for SB 612 retained the Coalition's transparency, clinical review criteria, and appeal process goals. The main changes are as follows:

1. Requires an electronic prior authorization process.
2. Utilization review criteria may be developed by an entity that works directly with clinicians (internal or external) if the entity does not have a financial stake in the outcome of the clinical care decision.
3. Allows physicians who are conducting the prior authorization reviews to be employed by insurers.

4. Eliminates the requirement that a physician making an adverse determination must be in the same specialty as the provider who typically manages the condition. This requirement is still intact for appeals.
5. Alters the timelines for urgent and non-urgent requests by changing hours to day - - urgent reviews must be done within one business day and non-urgent reviews within two business days and not to exceed seven business days if additional information was needed from the provider.

Senate Bill 612 (S-1) is currently before the full Senate for consideration. MSMS's focus will be to get the bill voted out of the Senate as soon as possible after the election. Then, there will be about 10 session days to try to get a House hearing and action. Although Blue Cross Blue Shield of Michigan, Michigan Association of Health Plans, General Motors, and other business groups continue to oppose, the health care and consumer coalition is robust and most legislators have been receptive, as they, or a family member or friend, have experienced the hassles of prior authorization and step therapy.

Michigan Hospital Medicine Safety Consortium (HMS)

The Board of Directors had a presentation from Scott Flanders, MD, Program Director, Michigan Hospital Medicine Safety Consortium; Chief Clinical Strategy Officer at Michigan Medicine; and Professor of Internal Medicine - Hospital Medicine at the University of Michigan Medical School.

In April 2020, the Michigan Hospital Medicine Safety Consortium (HMS), with assistance from several BCBSM CQI's, launched a registry focused on patients with COVID-19 in Michigan hospitals in direct response to the global pandemic. This initiative, Mi-COVID19, consists of 40+ hospitals across the state of Michigan working together to improve care for patients with COVID-19. The goals of the registry are as follows:

- Identify factors associated with critical illness/severe course and outcomes
- Identify patient characteristics, care practices, and treatment regimens associated with improved outcomes
- Understand the long-term complications for hospitalized patients including subsequent rates of readmission, mortality, and return-to-normal activities
- Evaluate variability of care processes across Mi-COVID19 hospitals and identify processes associated with improved outcomes
- Utilizing established CQI models, facilitate improvement in care across Michigan hospitals

The registry showed that most patients come from home (80.5%) and most came through the emergency department (93%). The median age is 63 with a 50/50 balance across gender. 51.4% of patients were African American with many from the SE Michigan/ Detroit area. The median BMI is 30.6 with 60% non-smokers. Common comorbidities include: hypertension (65.4%); diabetes mellitus (36.8%); cardiovascular disease (26%); moderate/severe kidney disease (23.3%); and asthma prevalent (12.9%).

The prevalence of confirmed community-onset bacterial co-infections was low. Despite this, half of patients received early empiric antibacterial therapy. Antibacterial use varied widely by hospital. Reducing COVID-19 test turnaround time and supporting stewardship could improve antibacterial use.

Manuscripts on epidemiology and 60-day outcomes are under review. Additionally, analyses are in process for:

- Risk prediction model for severity of outcomes
- Variation in presenting illness severity over time and across hospitals.
- Use of intravascular devices and outcomes
- Co-infection rates and predictors for co-infection in patients hospitalized
- Health disparities
- Variability and outcomes with early steroids use in patients
- Use of opioids/sedatives
- Variation of in-hospital anticoagulation treatments and outcomes
- Mental health in discharged patients
- Obesity and mortality in patients

ONC "CURES ACT" INFORMATION BLOCKING RULE

Congress enacted the 21st Century Cures Act (the "Cures Act") in 2016 to address the use and exchange of health data through health information technology (HIT), strengthen interoperability, promote patient access to electronic health information (EHI), and prevent information blocking. The Cures Act and its administrative rules regulate health care providers (including physicians in private practice and their medical practices), HIT developers of certified health IT, health information exchanges, and health information networks. Compliance with HIPAA continues, but HIPAA covered entities (including hospitals, physicians and their business associates) also will need to comply with applicable requirements established by the Cures Act and its administrative rules. For

health care providers and their business associates, this means that some disclosures which are permissive under HIPAA may become mandatory disclosures under the Cures Act and its administrative rules.

In May 2020, the HHS Office of the National Coordinator for Health Information Technology (ONC) published its final rule on Interoperability, Information Blocking, and the ONC Health IT Certification Program (the "Final Rule"). The Final Rule clarifies when information blocking occurs (the "Information Blocking provisions") and updates ONC's HIT certification criteria. The Information Blocking provisions apply to health care providers, HIT developers of certified health IT, health information exchanges, and health information networks (collectively "Actors"). Actors must comply with the Information Blocking provisions of the Final Rule by November 2, 2020. However, there is a three-month enforcement discretion period which runs through February 2, 2021. The government's announcement does not refer to this as a delay in enforcement, but states that enforcement will be discretionary during this period. "This additional flexibility for development and implementation enables our healthcare system to focus on addressing the COVID-19 pandemic, while still maintaining a trajectory that will advance patients' access to their health information, reduce the cost of care, and improve the quality of care."

For health care providers, "Information blocking" generally means a practice that the provider knows is "unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information." Beginning November 2, 2020, subject to limited exclusions and exceptions, eight types of clinical notes, outlined in the United States Core Data for Interoperability (USCDI), must be shared: consultation notes, discharge summary notes, history and physical, imaging narratives, laboratory report narratives, pathology report narratives, procedure notes, and progress notes. Notes which qualify as psychotherapy notes under HIPAA are excluded. Also excluded is information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative proceeding.

In addition to the exclusions, the Final Rule provides exceptions to the Information Blocking provisions (the "Information Blocking Exceptions"). Thus, an Actor will not be deemed to engage in information blocking if the Actor's conduct falls within an Information Blocking Exception. There are eight exceptions. Five of the exceptions involve not fulfilling requests to access, exchange, or use EHI: the preventing harm exception, the privacy exception, the security exception, the infeasibility exception, and the HIT performance exception. The three remaining exceptions involve procedures for fulfilling requests to access, exchange or use EHI: the content and manner exception, the fees exception and the licensing exception.

There are many open issues that physicians and other providers will need to work through as the Information Blocking and Cures Act provisions are implemented. For example, will physicians be required to establish portals for patients to access specified health information in real-time? Physicians and other providers should begin assessing the capabilities of their portals and other electronic systems in order to determine how they will comply with the Information Blocking rules. As the Information Blocking and other Cures Act provisions are implemented over the coming months, look for MSMS to continue providing educational resources to physicians and their practices.

MIOSHA ISSUES EMERGENCY RULES TO CLARIFY REQUIREMENTS FOR EMPLOYERS TO CONTROL, PREVENT, AND MITIGATE THE SPREAD OF INFECTION

The Michigan Occupational Safety and Health Administration (MIOSHA) within the Michigan Dept. of Labor and Economic Opportunity (LEO) is one of the first state OSHA programs to promulgate rules which clarify the safety requirements employers must follow to protect their employees from COVID-19. On October 14, Governor Gretchen Whitmer signed her concurrence of the need for a comprehensive set of Emergency Rules that will help protect Michigan workers, businesses, customers and communities from the spread of COVID-19.

Under the Emergency Rules, businesses that resume in-person work must, among other things, have a written COVID-19 preparedness and response plan and provide thorough training to their employees that covers, at a minimum, workplace infection-control practices, the proper use of personal protection equipment (PPE), steps workers must take to notify the business or operation of any symptoms of COVID-19 or a suspected or confirmed diagnosis of COVID-19, and how to report unsafe working conditions.

MIOSHA's Emergency Rules implement workplace safeguards for all Michigan businesses and specific requirements for industries, including manufacturing, construction, retail, health care, exercise

facilities, restaurants and bars.

The rules establish workplace safety requirements and employers should coordinate these requirements with the Emergency Order issued by the Michigan Department of Health and Human Services restricting gathering sizes, requiring face coverings in public spaces and childcare facilities, placing capacity limitations on stores, bars and other public venues and providing safer workplaces.

A set of online resources at Michigan.gov/COVIDWorkplaceSafety provides businesses with the guidelines they and their employees must follow and includes a sample COVID-19 preparedness and response plan and a reopening checklist to help businesses put safeguards in place. Businesses can also find posters for employees and customers, factsheets and educational videos.

To enhance MIOSHA's consultative services, the newly launched MIOSHA Ambassador Program will send safety and health experts to businesses statewide now to offer education and support, with a focus on workplaces with a higher risk of community transmission. To request consultation, education and training services, call 517-284-7720 or online at MIOSHA Request for Consultative Assistance.

For more information about MIOSHA's safety and health guidelines to protect Michigan's workforce during the pandemic, visit Michigan.gov/COVIDWorkplaceSafety. Employers and employees with questions regarding workplace safety and health may contact MIOSHA using the new hotline at 855-SAFE-C19 (855-723-3219).

To report health and safety concerns in the workplace, go to Michigan.gov/MIOSHAcomplaint.

PUT SHOTS IN MCIR

The Michigan Department of Health and Human Services (MDHHS) has a statewide goal of increasing flu vaccines by 33% this season.

Keeping up-to-date immunization records in the Michigan Care Improvement Registry (MCIR) is crucial to track this effort. The Regional MCIR Team is available to assist physicians and providers with topics like How to Add an Immunization or How to Balance your Vaccine Inventory in MCIR.

Physicians and providers who immunize children born after December 31, 1993 and less than 20 years of age must report all vaccines within 72 hours of administration. Entering adult immunizations is highly recommended to ensure a more accurate, robust registry. Visit www.mcir.org for a variety of resources on how to use MCIR and how to contact MCIR staff for trainings.

MSMS WEBSITE TO GET PPE FOR PHYSICIAN PRACTICES

The Michigan State Medical Society, in partnership with Foresight Group, launched a website, http://MSMS.org/PPESupplies, to get personal protective equipment and other supplies for Michigan's physician practices. The website allows physicians and their practices to purchase essential medical supplies, including respirators, face shields, goggles, and gowns.

Once the practice identifies their need and quantity, information is shared with Foresight Group, who will then identify the best rate and delivery times available, confirm need with the practice, collect payment information, and place the order, which will then ship directly to the practice.

If there are specific supplies needed, please notify MSMS@MSMS.org so those supplies may be added as an option.

FREE MSMS ON-DEMAND WEBINARS

MSMS is offering members the following on-demand webinars for free. To access them go to their website at https://www.msms.org/Education.

COVID-19: CARES Act Impact
CME Credits: 0.50

COVID-19: Telemedicine and Other Technology Codes in a COVID-19 Environment
CME Credits: 0.75

COVID-19: What Physicians Need to Know as Employers During the COVID-19 Pandemic
CME Credits: 1.00

Health Care Provider's Role in Screening and Counseling for Interpersonal and Domestic Violence: Dilemmas and Opportunities
CME Credits: 0.50

McLaren Macomb Hospital

MCLAREN MACOMB EXPANDS SURGICAL TECHNOLOGY

McLaren Macomb has expanded its surgical services with the addition of two leading-edge pieces of technology to treat conditions common to the public.

Offering an increased level of precision, the MR Fusion Prostate Biopsy provides a less invasive option to successfully biopsy suspected prostate cancer lesions and tumors, selectively targeting more aggressive forms of cancer, leading to reduced occurrences of false positives.

With more than 180,000 new cases every year, prostate cancer is one of the most common forms of cancer, affecting one in seven.

Suspected areas are first identified by MRI and marked by radiologists. An enhanced 3D image of the prostate is rendered and, under ultrasound guidance, surgeons perform the biopsy assisted by robotic technology, ensuring only suspected areas are targeted and healthy tissue is spared.

Additionally, McLaren Macomb also added an Ureterolithotripsy (URS) Laser Lithotripsy Service, a non-invasive alternative to the surgical removal of kidney, gallbladder or ureter stones - stones large and small, and in any location in the body.

While stones don't often leave permanent damage, they can be painful to pass. The procedure uses the latest imaging technology and laser system to fragment the stone, allowing the patient to safely and painlessly pass it through the body.

Learn more about surgical services at McLaren Macomb at mclaren.org/macombsurgery.

NEW CT UNIT BOOSTS CAPACITY BY 25 PERCENT, INCREASES IMAGING EFFICIENCY

When the Wayne and Joan Webber Emergency and Trauma Center opened in the summer, one of the features was an on-site CT scanner with room for a second.

The new 128-slice unit boasts a lower radiation dose (60-80 percent lower) while still producing high-quality images, with 43-80 percent image detectability.

The addition of this second unit in the emergency department marks the fourth fixed CT unit in McLaren Macomb, increasing the hospital's CT imaging capacity by 25 percent. This will allow for an alleviation of imaging case congestion, increasing the department's efficiency and freeing up other units for procedures.

This project is the result of a multidisciplinary team collaboration, motivated to benefit patient care and experience.

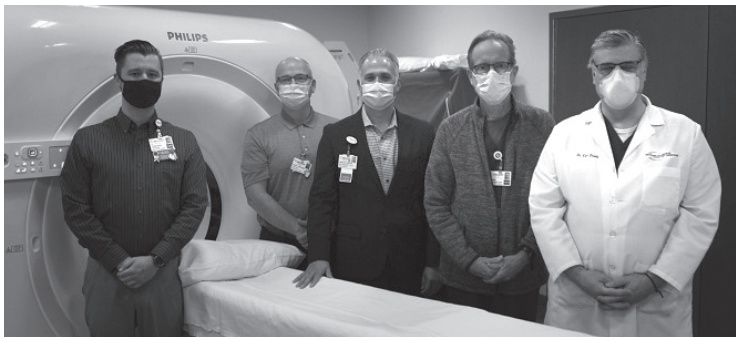


Photo L-R: Trevor London, manager, imaging services; David Gaffney, director, imaging services; Tim Vargas, McLaren Macomb COO; Mike Adams, CT lead technologist; Dr. Karl Doelle, radiologist and medical director of imaging services

MCLAREN MACOMB EARNS 'HIGH PERFORMING' MARKS IN ITS CARE FOR HEART FAILURE AND COPD FROM U.S. NEWS & WORLD REPORT

McLaren Macomb has been recognized by U.S. News & World Report for its treatment of common, quality-of-life hindering conditions.

In its annual hospital ranking, U.S. News & World Report ranked McLaren Macomb 'high performing' in its treatment and care of heart failure and chronic obstructive pulmonary disease (COPD).

Being named to the distinguished list ranks a health care provider's proficiency in delivering care, taking into account the patients' outcomes and experience.

Ranking is based on an analysis of patient outcomes and care-related factors, such as patient safety and nurse staffing, from approximately 5,000 hospitals nationwide.

Heart failure, also referred to as congestive heart failure, occurs when the muscles of the heart fail to pump enough blood to the rest of the body. COPD is an inflammation of the lungs that can lead to obstructed airflow and difficulty breathing.

Very common conditions afflicting millions of Americans, both heart failure and COPD are chronic conditions that must be managed by a physicians.

Henry Ford Macomb Hospital

HENRY FORD STUDY: UV-C LIGHT IS EFFECTIVE FOR KILLING COVID-19 ON N95S

Dermatology researchers at Henry Ford Health System, in collaboration with a team at the University of Michigan, have demonstrated that certain N95 respirators tainted with COVID-19 can be effectively and safely decontaminated for reuse using ultraviolet-C light (UV-C), a method commonly utilized for treating rare skin diseases.

Researchers say the outside and inside of the facemasks were decontaminated in a prototype phototherapy unit that dispenses a UV-C dosing level high enough to effectively kill the virus in less than two minutes while still preserving the facemask's breathability, fit and overall integrity.

Of the five N95s used at Henry Ford and tested for the coronavirus in the study, the decontamination process worked best on two models - facepieces on 3M 1860 and Moldex 1511 and straps on 3M 8210 and Moldex 1511. The effects of the dosage varied on the other tested models and their straps, suggesting that the UV-C radiation can degrade them. Researchers say wiping the straps with ethanol before decontamination would likely be required as an additional disinfection step in the process to maximize the wearer's safety.

Researchers emphasized that fit testing be required each time a disinfected facemask is returned for use or a new model is being worn for the first time.

The research, conducted in partnership with the University of Michigan, is published in the International Journal of Infectious Diseases.

"Our findings reveal a practical, and viable option should hospitals encounter shortages of N95s in the future," says David Ozog, MD, chair of Henry Ford's Department of Dermatology in Detroit. "Using UV-C has been shown to be effective in killing other coronaviruses and the flu virus. We were able to replicate that sterilization effectiveness with COVID-19."

Ozog stressed that facemask sterilization should only be used in severe shortages of N95s.

The research culminated the work of a team of dermatologists and researchers who have devoted more than 400 hours since the pandemic hit Michigan to investigating how phototherapy - a type of medical treatment used for treating certain skin conditions - could serve a role in the global health emergency. The Henry Ford team includes Henry Lim, MD, and Iltefat Hamzavi, MD, both of whom are internationally recognized for their expertise using phototherapy for treating rare skin diseases like vitiligo and hidradenitis suppurativa.

The pandemic exposed a critical flaw in the global PPE supply chain as the health care industry struggled to obtain supplies of N95s, other facemask types, gowns, gloves and face shields. As a result, decontaminating N95s to be reused safely became essential for many

health care systems and providers until new shipments of supplies arrived. Henry Ford decontaminated thousands of N95s and returned them to their user for reuse in the first couple months of the pandemic.

Henry Ford's phototherapy unit was modified with the help of engineers at Daavlin Co., a phototherapy manufacturer based in Bryan, Ohio. It sits on a flat surface and is about five feet long. The decontamination field measures 15 inches deep by 45 inches long - plenty room to treat up to 27 facemasks at one time. The ultraviolet light is powered by at least 10 but not more than 20 UV-C lamps.

The effectiveness of decontamination was measured in analytical chemistry terms by the limit of detection (LOD) and no cytopathic effect (CPE). LOD is the minimum concentration of a component that can be reliably detected. CPE means the virus yielded no infectious properties.

All five facepieces had below LOD and no CPE but some had traces of the virus on their straps, according to the research.

Researchers cautioned that none of the N95s tested were visibly soiled. Most health systems including Henry Ford prohibit the reuse of soiled N95s.

"Given the current COVID-19 pandemic, extreme measures are needed to keep those on the front line protected," says Angela Torres, MD, a Henry Ford dermatology fellow and lead author in a study published online in Photochemical & Photobiological Sciences. "These options are cost effective, quick to employ and have the potential to save many lives and valuable resources."

However, Dr. Torres says, discarding a contaminated disposable N95 after a single use is "still ideal."

PANDEMIC MUST-HAVES: PPE AND CLEAN, SANITIZED SCRUBS & GOWNS

Personal protective equipment like facemasks, gloves and gowns are life-saving must-haves for healthcare providers, and never more so than in the fight against COVID-19. Just as critical is an ample supply of clean and sanitized scrubs for healthcare workers and fresh gowns and bed linens for patients.

With COVID-19 cases on the rise in Michigan and flu season approaching, there will be increased demand for clean laundry. What better way to meet that need than a modern medical laundry facility that washes, presses and folds 700,000 pounds of laundry every week.

Henry Ford Health System, Michigan Medicine and Saint Joseph Mercy

Health System unveiled their $48 million shared laundry facility that is expected to achieve both significant savings from more efficient operations and better meet the needs of these three health systems. Located in the city of Detroit, the new eco-friendly facility has the capacity to service 78 million pounds of health care linens - scrubs, bed sheets, pillowcases, blankets, towels and scrubs for inpatient and outpatient use - every year for the health systems combined.

"Our collaboration is a true model for how health care institutions can work together to achieve efficiencies and spur economic renewal in our region," said Bob Riney, Henry Ford's president of Healthcare Operations and chief operating officer. "Laundry service is critical to our everyday operations for our patients and team members, and this investment will have meaningful impact for years to come."

Since opening June 1, the facility has been running two shifts over a six-day work week. At 115,000-square feet, it is one of the largest shared medical laundry facilities in the country and more than double the size of the previous laundry plant. It is on track to service about 34 million pounds of laundry by year's end. That includes a new piece of apparel - a washable medical gown that will extend the supply of a valuable piece of PPE for frontline workers. Made of polymer fabric, the gown can be washed 100 times before it needs to be discarded.

"We've already seen the benefits of partnering with peer health systems to improve service and reduce costs. I am proud of our collective efforts to invest in a modern facility, new jobs and to provide highly reliable service. Locating the facility in Detroit supports U-M's commitment to the city," said Tony Denton, senior vice president and chief operating officer of the U-M Health System for Michigan Medicine. "While it all takes place behind the scenes, laundry and linen services are essential to the daily provision of health care services, with emphasis on patient and caregiver safety."

"This laundry facility illustrates how the health care industry can come together to share efficiencies that lower the cost of health care, and ultimately, improve patient experience," said Rob Casalou, president and CEO, Trinity Health Michigan. "Some of the employees at the facility have worked there for decades, and we are thrilled that this facility is now providing more jobs in a state-of-the-art, safe work environment in Detroit."

The sprawling facility combines automated technology with numerous sustainable initiatives to minimize operating costs and responsibly steward the environment.

STUDY SHOWS ANTIBIOTICS MAY BE VIABLE OPTION FOR APPENDICITIS INSTEAD OF SURGERY

Every year more than 250,000 people undergo surgery for appendicitis, making it one of the 20 most common surgeries performed in the United States.

In the largest randomized US study of appendicitis published October 5, 2020 in the New England Journal of Medicine, researchers from Henry Ford Health System and 24 other sites around the US report that seven in 10 patients who received antibiotics avoided surgery and that patients who took antibiotics for symptom relief fared no worse in the short term than those who underwent surgery.

Still, researchers cautioned that taking antibiotics for appendicitis is not for everyone and advised patients to consult with their physician.

"The significance of this study means that surgeons and patients now have more options for the treatment of appendicitis," says J.H. "Pat" Patton, MD, medical director of Surgical Services for Henry Ford Health System and a study co-investigator. "We now know that we can safely and effectively treat a significant number of patients with antibiotics alone and avoid surgery. We encourage patients to weigh their options based on their individual circumstances before deciding which treatment is best for them."

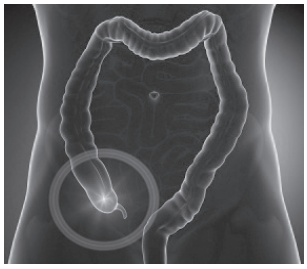
Henry Ford was among 25 US sites in 14 states that participated in the study, Comparing Outcomes of Antibiotic Drugs and Appendectomy (CODA). With 1,552 patients studied between May 3, 2016 and Feb. 2, 2020, CODA represents the largest study comparing surgery and antibiotics in adults with appendicitis and is roughly three times larger than the previous one. The study was funded by the Patient-Centered Outcome Research Institute.

Unlike prior studies, CODA was the first to include patients with severe appendicitis and a condition called appendicolith, in which a small stone forms in the appendix. Researchers originally planned to report their findings after patients recovered for one year. With concern about limiting unneeded surgeries during the height of the COVID-19 pandemic, researchers decided to reduce the time frame for reporting results following either surgical or antibiotic intervention to 90 days in order to give physician data on the effectiveness of this non-surgical option.

Key findings of the study:

- Seven in ten patients who received antibiotics avoided surgery within the first 90 days following treatment, while three in ten did eventually need surgery within the same time frame
- Four in ten patients with an appendicolith who received antibiotics required surgery within 90 days of receiving antibiotics as their first treatment
- Patients treated with either antibiotics or surgery experienced symptoms of appendicitis for about the same amount of time prior to treatment

- Patient treated with antibiotics missed less time from work or school but reported more visits to the Emergency Department and days spent in the hospital overall than those who had surgery



Researchers acknowledge that the study's timing in the middle of a pandemic could have broad implications for both patients and hospitals. Risk of COVID-19 exposure or going to a hospital continues to be a real concern for patients who may find antibiotic treatment a preferred choice. The study also provides hospitals with clarifying options as they prepare for a possible surge of COVID-19 cases this fall and winter. Because of health care disparities highlighted in the pandemic, Dr. Patton cautions that doctors be mindful of properly addressing vulnerable patient populations on the implications of the study.

"We recognize some patients may not want to come into a hospital environment during a pandemic. This study tells us that antibiotics are a viable option for some of these patients," Dr. Patton says. "And as the data are starting to show, patients who are COVID positive and undergo general anesthetic may have more complications than they may otherwise have. If we can treat patients successfully on an outpatient basis, we can keep them out of the hospital and preserve resources for other types of surgeries."

Jeffrey Johnson, MD, medical director of Trauma at Henry Ford Hospital and co-investigator on the CODA trial, recommends that patients assess all their options with their doctor.

"Beyond the treatment itself, patients need to fully explore their medical condition and personal factors like time off from work and school, insurance coverage and caregiving responsibilities when making their decision," Dr. Johnson says. "What this study shows is there is no one-size-fits-all approach. Patients ought to evaluate the benefits and risks of taking antibiotics or opting for surgery and make an informed decision on what is important to them."

In the study 776 patients were randomly assigned to receive antibiotics and 776 patients to undergo appendectomy. Patients' median age was 38 and 63 percent were men and 37 percent women. The ethnic background was 60 percent white, 23 percent other, 5 percent Asian, 2 percent American Indian or Alaska Native and 1 percent Native Hawaiian or Pacific Islander.

Patients in the antibiotics group received a 10-day course of antibiotics based on guidelines from the Surgical Infection Society and Infectious Diseases Society of America.

Of the 1,552 patients, 172 were enrolled at Henry Ford Hospital, the health system's hospital in Detroit.

Researchers will be reporting on additional findings from data that continues to be collected from patients. Future analysis will examine long-term quality of life, recurrence of appendicitis in the antibiotics group and predictors of outcomes based on patient characteristics among other topics.

HENRY FORD HEALTH SYSTEM NAMED LGBTQ EQUALITY LEADER FOR EQUITY, INCLUSION

Henry Ford Health System has been recognized as an "LGTBQ Healthcare Equality Leader" by the Human Rights Campaign Foundation (HRC) for its commitment to providing equitable and inclusive care and support for lesbian, gay, bisexual, transgender and questioning patients and employees.

Henry Ford is one of only two health systems in Michigan recognized as a destination for LGBTQ care, employment and community partnerships.

In a separate national honor, the American Hospital Association (AHA) recently recognized Henry Ford as a 2020 Carolyn Boone Lewis Equity Care Award honoree for its efforts to reduce healthcare inequities and advance diversity and inclusion.

The HRC designation was awarded based on the Healthcare Equality Index (HEI), the national LGBTQ benchmarking tool that evaluates healthcare facilities' policies and practices related to the equity and inclusion of LGBTQ patients, visitors and employees.

"We are incredibly proud of the dedication of our many teams that provide the best care for everyone in our LGBTQ communities," says Kimberlydawn Wisdom, M.D., Henry Ford's senior vice president of Community Health & Equity and Chief Wellness & Diversity Officer. "We are honored to be recognized for our unwavering commitment to steadily drive healthcare equity across all the diverse communities that we serve."

Inclusion on the list is based on participating healthcare facilities recognizing the importance of implementing LGBTQ-inclusive practices alongside their foundational non-discrimination policies.

"Henry Ford hospitals have been recognized since 2013 for fostering practices of inclusivity and 2020 was the most significant year to continue their efforts to highlight that commitment," says HRC president Alfonso David. "We extend our deepest gratitude to these facilities for their commitment to address racism and injustice while courageously fighting against COVID-19."

For Henry Ford's AHA honoree recognition, AHA president and CEO, Rick Pollack noted, "we commend Henry Ford for demonstrating an enduring commitment to health equity, cultural competency and for confronting unconscious bias."

The AHA highlighted Henry Ford's "We Ask Because We Care" campaign that collects racial, ethnicity and language preference information from patients and is used to reduce health disparities and improve health outcomes in maternal and infant health, diabetes management and prevention and other areas. The organization was also recognized for diversity among its top leadership. The health system's senior leadership is currently 50% female and 43% non-white.

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IMPORTANT INFORMATION FOR LICENSEE IDENTITY PROTECTION

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- Be suspicious of any unexpected emails or links to websites. If your personal

information is compromised, it may be used in other fraud schemes.

- Do not respond to or open hyperlinks in emails or text messages requesting to validate your personal data.
- Do not share your licensing, personal, or financial information over the telephone or via text message with a purported representative of the Department. If asked for sensitive information, please request the representative to contact you from a michigan.gov email account or provide you with an official request by mail. You may also contact us at the email address or phone number below to verify if the Department is requesting any information from you.
- If there are any hyperlinks, check the link or URL before clicking. LARA websites will have the "Michigan.gov" domain name.
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Top 7 Tips for Telehealth During COVID-19

David L. Feldman, MD, MBA, FACS, Chief Medical Officer, The Doctors Company

THOUGH TELEHEALTH WAS AN ESTABLISHED METHOD OF DELIVERING CARE BEFORE THE COVID-19 PANDEMIC, IT HAS COME INTO FOCUS AS PHYSICIANS FACE AN IMMEDIATE NEED TO REDUCE EXPOSURE BY PROVIDING CARE - OR AT LEAST TRIAGE - REMOTELY WHEN APPROPRIATE.

Under usual circumstances, telemedicine is comparatively low risk. That said, telemedicine does bring certain specific risks to both patient safety and physician/practice liability. Minimizing those risks calls for adapting daily practice routines around informed consent, documentation, and other standard components of a patient encounter, as well as adjusting the practice's insurance coverage.

The following are seven recommendations for any medical practice starting to provide care via telemedicine:

1. Distinguish between new and established patients.

The foundation of care remains the physician-patient relationship. If someone you were seeing before this pandemic calls with a problem, it's reasonable to either speak to them on the phone or have some kind of video chat.

With new patients, however, proceed with caution. Likely your state or your insurance carrier usually requires that your first visit with a patient be in-person. During this pandemic, such restrictions may be relaxed - but just because you can treat a new patient by telehealth, doesn't mean you should. A new patient may be more difficult to assess by remote means, and new patients are also more likely to be experiencing an acute situation that is not appropriate to treat by telehealth.

2. Maintain privacy.

Consider who is in the physical space or within listening distance of the patient-physician conversation when treating patients by phone or video chat. This includes other people in their space - and also yours.

Physician-patient conversations are confidential. It's up to the patient to determine who might be with them in their home environment during that visit, but it's the physician's responsibility to discuss the question of confidentiality. Also, you want the patient to know who from your staff is participating - unlike with an office visit, they may not know who's in the room.

3. Prepare the patient before the appointment.

Talk to your patient about whether it is in their best interests to pursue care by remote or virtual visit. This obviously depends upon your specialty, the patient's presenting concerns, etc. When using this modality, as with any other, let patients know that they have a right to stop or refuse treatment.

Consider not only your technology, but what patients are using. Have your staff review technology needs with patients before you begin.

Receive informed consent from the patient to treat them by telehealth. This conversation doesn't take long. A telehealth-specific informed consent form may already exist within your EHR system. As an alternative, The Doctors Company has created a sample informed consent that you can adapt to your practice. But at minimum, get your patient's verbal consent to consult by telehealth - and document that approval in the patient's record - before forging ahead.

Agree with your patient what you'll do if there's a technology malfunction, whether it's to resume by phone or have the patient come to the office in person.

You also want to talk to the patient about what telehealth means for billing. You may tell them, here's what your insurance company says about it - or, we don't know what your insurance company is going to say about it. States and insurers are making a variety of exceptions to their usual rules during COVID-19 - but the exceptions keep changing, so billing is a moving target.

First and foremost, do what you think is in your patient's best interest as guided by good clinical judgment. Physicians need to be able to support their practices, but the payment has to come secondary to doing the best for your patient in the environment we're in. We're in a tough, confusing situation, but I believe that physicians are going to do the right thing, and that's really what counts.

The Centers for Medicare and Medicaid Services are periodically posting payment updates. Also check the webpage for your state's health authority for updates regarding state-to-state licensing issues.

4. Develop your web-side manner.

Consider your surroundings as you prepare for video visits. You may realize that the brightly colored and patterned wall-hanging behind you could be distracting, and choose a plainer background. If you

are video-consulting with patients from a guest room in your home that has been hastily converted into an office, imagine the visit from the patient's point of view: You'll quickly think to turn the camera so that the background is your desk, not the guest bed, for a more professional tone.

With newer patients, consider donning your white coat, if you weren't wearing it already - and make sure your badge is visible. Clothing does look different on camera than it does in person, so when possible, choose solid colors over multicolored patterns, which can create a rainbow effect. Good colors for video include earth tones, deep blues, purples, and teal green.

A little common sense will go a long way in removing distractions and maintaining a professional tone during telehealth visits.

5. Call on creativity to "examine" patients remotely.

It is true that some symptoms and conditions simply must be evaluated in person, and are not appropriate for care by telehealth. However, a virtual exam may be more informative than you'd think. For instance, one can assess for peritonitis by asking the patient to jump up and down. Musculoskeletal injuries may be assessed using the Ottawa knee and ankle rules. The Roth Score allows a preliminary assessment for shortness of breath and by simply asking the patient to take a deep breath and count out loud to 30 - potential COVID-19 patients may be unable to get past seven. For more information about remote evaluation tools, start with the April 2020 article in NEJM Catalyst, "The Transition from Reimagining to Recreating Health Care Is Now."

6. Consider additional insurance needs.

The COVID-19 crisis takes cybersecurity and cyber insurance needs to another level, because remote conversations with patients mean heightened risk for cybercrime. Consider seeking increased cybersecurity coverage during this time.

This is also a good opportunity to review your business associate agreements with technology providers to understand who will be liable in case of a breach. Privacy liability is critical.

Business interruption insurance also comes into focus now, because if you're primarily delivering care via telehealth, any interruption in your communication technology can be considered business interruption. Consider adding or increasing your coverage in this area.

"The COVID-19 crisis takes cybersecurity and cyber insurance needs to another level, because remote conversations with patients mean heightened risk for cybercrime."

7. Acknowledge when telehealth is not appropriate.

A physician using best judgment can say to a patient, it's hard for me to fully evaluate your symptoms using this kind of encounter, and I need you to come in. It's easier to miss things with telehealth, so when you have that second sense you're missing something - act on it.

Of the telehealth-related claims we've seen at The Doctors Company, nearly 70 percent have alleged diagnostic errors, and most of those involved cancer. The risk of missing a cancer diagnosis by telehealth depends in part on what kind of physician you are.

Remember that a virtual visit is the next best thing - but not the best thing. If you in your best judgment think a physical exam is called for, and you think the risk of them coming to your office is less than the risk of not seeing them, then you should have them come to your office.

For questions regarding HIPAA compliance with telehealth, and treating patients across state lines, please see our Telehealth Resource Center.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

Navigating COVID-19 with your Humanity, Sanity and Team Still in Tact

By: Jodi Schafer, SPHR, SHRM-SCP, owner of Human Resource Management Services, LLC

Amid all of the chaos, confusion and anxiety that has resulted from the COVID-19 pandemic, leadership has never been more important. To survive (and dare I say 'thrive'), leaders must adopt a mindset that allows you to put one foot in front of the other, especially when it's hard. Challenges can be viewed as stressful and overwhelming or challenges can be viewed as opportunities. Your mindset will determine how you feel about the situation that surrounds you and will heavily influence your success in our current reality. Now is the time to refocus. Here are four key strategies for navigating COVID-19 with your humanity, your sanity and your team still intact.

#1: Stay Connected: Regardless of which end of the -busy' spectrum your practice is on right now, carving out time to touch base with your team is paramount. The self-preservation instinct has kicked into overdrive for many people and their orientation has been shifted to look for the danger. In the absence of information, people will fill in the gaps of understanding with their own conclusions. Rarely does this bode well. You team needs to know that you care about them, that you are in this with them and that you are working on plans to secure the viability of the business so that you can all return to some sense of normalcy in the future. Connection can happen through face-to-face conversations, through daily or weekly update emails, phone calls, text messages, videos or zoom meetings. The frequency is almost as important as the content. Be intentional with these touchpoints - especially when you are physically separated. We all need to be reminded that there are brighter days ahead.

#2: Grant Grace: COVID-19 has turned our world upside down. Nothing is as it was and to pretend otherwise is not only naive, but detrimental. Teams are having to find new ways to perform job functions. Practices have implemented physical changes to their workspace to limit contact and the spread of this virus. Some workers are attempting to do their jobs from home, often with spouses and kids occupying the same space at the same time. It's not normal. There will be disruptions. There will be competing priorities. There will be frustration and non-productive time and technology challenges. Take a breath, let the little things go and allow others to do the same. Granting grace is granting permission for life to be messy sometimes and for each of us to be human. Provide flexibility where you can and tell your team to take a break when you can see that they need one. Give yourself that same permission. This is a marathon, not a sprint.

#3: Orient Towards the Positive: While this is an unprecedented time for all of us, it is not without hope and light. We need to be reminded of the good to keep our energy up and our outlook positive. You could start each shift meeting with everyone sharing something they are grateful for. You could highlight the number of COVID patients successfully treated and discharged. You could ask your team to participate in a volunteer effort. If you have staff working remotely or not at all right now, you could include them in a virtual recipe exchange, a virtual happy hour or a fun contest of some sort. Take time to fill your tank and gain perspective. You'll need to draw on these pick-me-up moments during the hard times ahead.

#4: Be Transparent: The only constant in this world is change and boy has that been the case lately! Don't let fear of making the wrong choice stop you from making any choice. Push forward with the information you have and let your team know the WHY behind your decisions. Provide opportunities for questions and suggestions and be willing to reconsider your options if/when additional guidance and support becomes available. Prepare your teams for operating with a degree of unknown and provide them with regular updates to keep their focus on what you DO know vs. what you DON'T. Remember, communication is key, but it has to be honest, transparent, authentic communication if you want to keep everyone moving forward.

While we can't accurately predict what the days ahead will bring, we do have the ability to control our responses and to identify lifelines that will guide us through these uncharted waters. To use a sports clichÈ, -It's game time'! Your employees are watching how you perform under this pressure. Your patients are watching how quickly you adapt to change and how deftly you respond to their fears and their needs. Your colleagues are watching. Your community is watching. The whole world is watching. Crisis reveals character and for those of you who have been putting in the work to fine-tune your leadership and communication skills over the years, it's about to pay off.

New Members

DANIEL S. MALACH, MD

Ophthalmology

Medical School: Wayne State University School of Medicine, 2016. Post Graduate Education: Beaumont Hospital, completed in 2017; Kresge Eye Institute, completed in 2020. Currently practicing at Metropolitan Eye Center, 21711 Greater Mack Ave, St. Clair Shores, MI 48080, ph. 586-774-0393, website: www.metropolitaneyecenter.com.

SATYUM R. PARIKH, MD

Physical Medicine & Rehabilitation

Medical School: Oakland University School of Medicine, 2016. Post Graduate Education: Beaumont Hospital; Marianjoy Rehabilitation Hospital (IL), completed in 2020. Hospital Affiliation: Ascension Macomb Oakland Hospital. Currently practicing at Center for Physician Medicine & Rehabilitation, 13850 E. 12 Mile Rd., Warren, MI 48088, ph. 586-552.-4499, fx. 586-552-4878.

MCMS and MSMS Member Dennis M. Ramus, MD, Appointed to BCBSM Board Position

With the transition of James D. Grant, MD, from a BCBSM Board member to the Chief Medical Officer position, BCBSM requested the Michigan State Medical Society (MSMS) submit two nominees for consideration to join the BCBSM Board for the remainder of Doctor Grant's unexpired term (through May 2022). The MSMS Representative to the BCBSM Board of Directors Selection Committee reviewed seven self-nominated candidate applications according to Board approved criteria. After reviewing candidate backgrounds to the selection criteria, the Committee narrowed to two physicians; and, both physicians were forwarded to BCBSM.

After BCBSM completed their selection process including interviews with both candidates, Dennis M. Ramus, MD, was appointed by the BCBSM Board of Directors to complete Doctor Grant's term.

Doctor Ramus, a member of the Macomb County Medical Society, is a family practice physician in Chesterfield and chair of The Physicians Alliance Physician Organization in SE Michigan. He is also PCMH credentialed through BCBSM. He has served on numerous BCBSM and PGIP committees throughout the years including the PGIP Medical Director Committee. Doctor Ramus is a long-time member of the MSMS Third Party Payer Committee and will now become an ex-officio member of the MSMS Board of Directors.

We believe Doctor Ramus is a superb clinician, well-respected leader within MSMS, and would assure strong physician representation on BCBSM Board.

SHARE YOUR NEWSWORTHY ITEMS

Have you or a MCMS colleague been elected to a position (specialty society, hospital, community based program, etc.) or honored for your volunteer service within the community or abroad? Let us know.

We would like to recognize MCMS members in the "Member News" section of the Medicus. Contact Heidi Leach at macombcms@gmail.com with newsworthy information.

Publication is subject to availability of space and the discretion of the Editor.

ASK OUR LAWYER

Is Anxiety About a Possible COVID-19 Infection Upon Returning to Work Considered a Disability?

By: Daniel J. Schulte, JD, MSMS Legal Counsel

Q *An employee is refusing to return to work. She tells us that she is afraid of COVID-19 infection and this fear is causing her to lose sleep and have anxiety and depression. I have been counseled on my right generally to terminate employees who refuse my recall to work. I am concerned to do so in this case because I have reason to believe this employee has sought treatment for anxiety and depression issues in the past. Should I be concerned about a disability discrimination claim if I terminate her employment? Could her suspected history of anxiety and depression (heightened by the COVID-19 crisis) be deemed a disability under some law?*

A You are right to be concerned about this. Generally, the Americans with Disabilities Act ("ADA") protects employees with mental health conditions that qualify as a disability. Employers must provide these employees with reasonable accommodations enabling them to do their jobs instead of disciplining or terminating them for not doing their jobs. Determining whether your employee has a condition that would be considered a disability and entitle them to this protection can be difficult to determine.

Not all mental health conditions will rise to the level of a covered disability. A general sense of nervousness, fear or anxiety arising from the possibility that as a result of returning to work you may become COVID-19 positive (even if real and tangible to the employee and honestly expressed) is not a disability under the ADA. Instead, only mental health conditions that are an impairment "substantially limiting a major life activity" (e.g. sleep, concentrating, communicating and other activities that effect an employee's ability to work) are deemed a disability under the ADA.

Employees experiencing mental health conditions must request accommodation (e.g. paid or unpaid leave) from their employer. This request should then trigger a dialogue with the employer concerning the issue. Employers have a right to ask for documentation from a doctor to verify the employee's condition. This determination may also include recommendations from the doctor as to the type and duration of accommodations that are necessary for the employee.

Assuming an employee requests accommodation and documentation has been obtained establishing that in fact the employee has a disability requiring reasonable accommodation under the ADA, the question then becomes what such a reasonable accommodation would be. Most employees in the situation you describe are seeking paid or unpaid leave for some period. If you decide leave is going to be the reasonable accommodation offered (because working from home or other accommodations are not possible) there is no legal requirement that the employee be paid while on this leave[1]. The duration of the leave then becomes the difficult question. Employers are not required to provide open-ended or indefinite leave. A duration can and should be set by the employer so that at some point it is known whether the employee can do the job and if not when a replacement employee must be found. There is no specific legal guidance that can be given as to the duration of leave in this situation. The best practice is to consider recommendations of the doctors, if any, and, to the extent possible, make the duration of leave consistent for all your employees having similar disabilities requesting leave as an accommodation. This will, to the extent possible, make any discrimination claims defensible.

In your case, since the employee did not tell you that she has a mental health condition constituting a disability (and/or provide you with documentation from her doctor describing her condition) and make a request of you for a reasonable accommodation you have no obligation to consider a leave or other request for accommodation on her behalf. Instead, you should decide whether to terminate or allow her to remain laid off.

1. I am assuming your practice has decided not to make paid leave pursuant to the Families First Coronavirus Response Act available to your employees and that your practice has less than 50 employees and the Family Medical Leave Act is not applicable.

ARE PHYSICIANS OBLIGED TO GET VACCINATED AGAINST COVID-19?

By: Kevin B. O'Reilly, AMA News Editor

When there's a safe, effective vaccine to help prevent spread of a pandemic disease, physicians without a medical contraindication have an ethical duty to become immunized.

That is among the recommendations contained in an AMA Council on Ethical and Judicial Affairs report adopted at the November 2020 AMA Special Meeting. The council's report, especially timely in light of encouraging news from SARS-CoV-2 vaccine trials during the COVID-19 pandemic, updates advice previously published in the AMA Code of Medical Ethics as opinion 8.7, "Routine Universal Immunization of Physicians."

"Physicians and other health care workers who decline to be immunized with a safe and effective vaccine, without a compelling medical reason, can pose an unnecessary medical risk to vulnerable patients or colleagues, said AMA Board Member Michael Suk, MD, JD, MPH, MBA. "Physicians must strike an ethical balance between their personal commitments as moral individuals and their obligations as medical professionals."

The ethical opinion adopted by the AMA House of Delegates says that doctors "have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings.

"In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe and effective vaccine, physicians have a responsibility to accept immunization absent a recognized medical contraindication or when a specific vaccine would pose a significant risk to the physician's patients," the new policy says.

"Physicians who are not, or cannot be, immunized have a responsibility to voluntarily take appropriate action to protect patients, fellow health care workers and others," says the ethical opinion. "They must adjust their practice activities in keeping with decisions of the medical staff, institutional policy, or public health policy, including refraining from direct patient contact when appropriate.

"Physician practices and health care institutions have a responsibility to proactively develop policies and procedures for responding to epidemic or pandemic disease with input from practicing physicians, institutional leadership, and appropriate specialists," says the updated opinion. "Such policies and procedures should include robust infection-control practices, provision and required use of appropriate protective equipment, and a process for making appropriate immunization readily available to staff. During outbreaks of vaccine-preventable disease for which there is a safe, effective vaccine, institutions' responsibility may extend to requiring immunization of staff.

"Physician practices and health care institutions have a further responsibility to limit patient and staff exposure to individuals who are not immunized, which may include requiring unimmunized individuals to refrain from direct patient contact," the ethical opinion concludes.

The COVID-19 pandemic is bringing new medical ethical questions to the forefront. The AMA is your source for guidance on ethical issues such as triage and resource allocation during COVID-19.

COVID-19 VACCINE MANDATES: WHAT PHYSICIANS SHOULD KNOW

With surveys showing that just about half of Americans surveyed would now be willing to get a COVID-19 vaccine when it becomes available - down from about 70% in May - some wonder whether vaccine mandates will be needed to achieve herd immunity.

During a recent "Ethics Talk" videocast from the AMA Journal of Ethics® (@JournalofEthics), Debbie Kaminer, JD, a professor in the Department of Law at the Zicklin School of Business, Baruch College in New York City explained that states and the federal government have the law on their side if they needed to enact mandates to ensure sufficient vaccination rates.

States already require school children to be vaccinated and court decisions have continuously upheld mandates, Kaminer said. In addition, as long as a mandate is neutral when it comes to religion and does not single out religious behavior, religious exemptions do not legally need to be written into the mandate.

But, Kaminer argued, that is not the best way to go about ensuring Americans get a COVID-19 vaccine.

Mandates "are heavy-handed," she said. "They can be divisive. They can backfire and then the end result is it's going to increase tensions," she said. "What you can have instead are more targeted policies."

Kaminer offered several simple, inexpensive actions that elected officials, community leaders and business leaders can take to encourage people to get vaccinations.

Maintain public trust

Public health entities need to maintain their credibility for people to be comfortable getting a COVID-19 vaccine.

"If people don't trust the government and the government announces that a vaccine is safe and effective, people are not going to get vaccinated," Kaminer said.

Traditionally, a small number of people were vaccine resistant or vaccine hesitant and not get the vaccine.

"What is so troubling in terms of a potential COVID-19 vaccine is now the very people who used to be first in line to get vaccinated are very skeptical that a vaccine may be fast-tracked by the Trump administration for political reasons and this can be very, very problematic," Kaminer said.

Target high-risk groups

One way to avoid mandates is to have targeted policies and to focus on those who are most likely to get ill or most likely to spread the disease.

For example, Kaminer said, COVID-19 spreads easily in indoor venues, so municipalities, states or Congress could pass a law that says you need to show proof of a vaccine to enter a bar, sporting event, concert or other activity that packs many people into small spaces. The idea is not much different than having to show proof of being 21 or older if you go into a bar and want a drink.

"It simply doesn't come across as heavy-handed," she argued.

Employers can take the lead

Health care and education workplaces have traditionally had vaccine requirements. Now that COVID-19 has left other workers' health at risk in an unprecedented way, employers can legally create policies requiring employees get vaccinated.

Whether the business is a bar, gym, restaurant or factory, the most important thing is transparency, Kaminer said. Business leaders should let employees know the purpose of the policy is to protect their health and jobs.

Lead by example

Business owners and executives can show their employees they are getting vaccinated. State officials also should get publicly vaccinated, Kaminer said.

Communicate a clear message

Elected officials can tell the community that they don't want to have to rely on a mandate to ensure people get vaccinated and emphasize that getting vaccinated is a way to protect others. Religious leaders, social media influencers, celebrities and other community leaders can also help spread the word about how important it is to get vaccinated.

"People don't want to view themselves as uncaring and disrespectful," Kaminer said. Realistically, she said she believes getting enough people vaccinated, will be "some combination of government mandates, employer mandates and also some of this messaging and nudging."

AMA ADOPTS NEW POLICY AIMED AT PREVENTING BULLYING IN MEDICINE

The American Medical Association (AMA) has adopted new policy aimed at preventing bullying among health care professionals. Specifically, the new policy, approved by physicians at the Special Meeting of the AMA House of Delegates, provides a formal definition of "workplace bullying" as well as guidelines for health care organizations, including academic medical centers, to use in developing policies, procedures, and training to help them prevent and address bullying in their workplaces.

The new policy also encourages health care organizations to create a culture in which bullying does not occur, and outlines guidance they can follow to foster respect and appreciation among colleagues across disciplines and ranks and ensure a safe work environment.

"Bullying in medicine not only negatively impacts the mental and physical health of the professional being bullied, but can also have lasting adverse effects on their patients, care teams, organizations, and their families. Bullying has no place in the medical profession and we must do everything we can to prevent it for the sake of the wellbeing of the health care workforce," said AMA Board Member

Willie Underwood III, M.D., MSc, MPH. "Putting an end to bullying in the practice of medicine will require the health care industry, local organizations and individual members of the health care team to acknowledge the problem, accept responsibility, and take action to address it at all possible levels."

In the health care setting, individuals who have been bullied have reported experiencing burnout, depression, anxiety and worsened performance. According to a 2008 report of The Joint Commission, intimidating and disruptive behavior can result in medical errors, poor patient satisfaction and preventable adverse outcomes. To help health care organizations prevent workplace bullying, the AMA's new policy offers the following guidance that should be used to establish an effective workplace policy:

- Describe the management's commitment to providing a safe and healthy workplace. Show the staff that their leaders are concerned about bullying and unprofessional behavior and that they take it seriously.
- Clearly define workplace violence, harassment, and bullying, specifically including intimidation, threats and other forms of aggressive behavior.
- Specify to whom the policy applies (i.e., medical staff, students, administration, patients, employees, contractors, vendors, etc.).
- Define both expected and prohibited behaviors.
- Outline steps for individuals to take when they feel they are a victim of workplace bullying.
- Provide contact information for a confidential means for documenting and reporting incidents.
- Prohibit retaliation and ensure privacy and confidentiality.
- Document training requirements and establish clear expectations about the training objectives.

Additionally, given the lack of a legal definition, the number and variety of definitions in use, and the continued need for more universally accepted policies to prevent bullying in the workplace, the AMA's policy provides an inclusive, universal definition of bullying. The AMA defines "workplace bullying" as repeated, emotionally or physically abusive, disrespectful, disruptive, inappropriate, insulting, intimidating, and/or threatening behavior targeted at a specific individual or a group of individuals that manifests from a real or perceived power imbalance and is often, but not always, intended to control, embarrass, undermine, threaten, or otherwise harm the target.

In light of ongoing attacks on physicians and public health officials during the COVID-19 pandemic, the AMA also adopted policy today aimed at improving the safety of and preventing violence against physicians, as well as other health care workers, first responders, and public health officials.

WHEN PATIENTS ARE PREJUDICED, HERE'S WHAT PHYSICIANS SHOULD DO

By: Kevin B. O'Reilly, AMA News Editor

About 70% of Black physicians have reported hearing offensive comments based on their personal characteristics, according to survey research cited in an AMA Council on Ethical and Judicial Affairs report adopted at the November 2020 AMA Special Meeting.

Overall, nearly six in 10 doctors have had such discriminatory patient encounters. In reference-committee testimony, physicians said the unacceptable behavior seems to be on the rise. The council's report details the problem and offers ethics guidance for physicians.

The AMA House of Delegates adopted the report's recommendations, which update advice previously published in the AMA Code of Medical Ethics as opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients."

"Disrespectful, derogatory, or prejudiced, language or conduct or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians can undermine trust and compromise the integrity of the patient-physician relationship," the council's report says. "It can make individuals who themselves experience (or are members of populations that have experienced) prejudice reluctant to seek care as patients or to provide care as health care professionals, and create an environment that strains relationships among patients, physicians, and the health care team."

According to the updated ethical opinion, physicians should:

- Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those who are targeted.
- Always treat patients with compassion and respect.
- Explore the reasons for which a patient behaves in disrespectful, derogatory or prejudiced ways insofar as possible. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.
- Prioritize the goals of care when deciding whether to decline or accommodate a patient's request for an alternative physician. Physicians should recognize that some requests for a concordant physician may be clinically useful or promote improved outcomes.
- Not forgo valuable trainee learning opportunities solely to accommodate prejudiced requests.
- Make patients aware that they are able

to seek care from other sources if they persist in opposing treatment from the physician assigned. If patients require immediate care, inform them that, unless they exercise their right to leave, care will be provided by appropriately qualified staff independent of their expressed preference.

- Terminate the patient-physician relationship only when the patient will not modify disrespectful, derogatory or prejudiced behavior that is within the patient's control, in keeping with ethics guidance.

Further, the ethical opinions says, physicians - especially those in leadership roles - should encourage the institutions with which they are affiliated to:

- Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.
- Educate staff, patients and the community about the institution's expectations for behavior.
- Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory or prejudiced behavior by patients will be managed.
- Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients, including allowing physicians, trainees, and facility personnel to decline to care for those patients, without penalty, who have exhibited discriminatory behavior specifically toward them.
- Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.

TO SUCCEED WITH TELEHEALTH, KNOW YOUR "WEBSIDE MANNER"

By: Timothy M. Smith, Senior AMA News Writer

Telehealth has been in some level of development in many U.S. physician practices for years, but the COVID-19 pandemic has thrust it to the forefront of patient care, often before doctors have been properly trained to do it.

A webinar hosted by Massachusetts General Hospital, "Crossing the Virtual Chasm: Rethinking Curriculum, Competency, and Culture in the Virtual Care Era," included five panel discussions with experts from around the country and focused on defining a framework for assessing competency for training in virtual care, as well as addressed challenges, workflows, strategies and best practices in virtual care enabled education.

Among the experts weighting in was Neel Naik, MD, director of emergency medicine simulation education and an assistant professor of clinical emergency medicine at Weill Cornell Medicine, in New York City, with best practices for adding warmth, clarity and, most important, effectiveness to telehealth visits.

New medium requires new skills

Dr. Naik and his colleagues at Weill Cornell Medicine and the institution's Center for Virtual Care developed a telemedicine training program for medical students long before the pandemic started. While there were lessons to be learned about the technical side of video visits, medical students most often wanted to talk about their interactions with patients.

"Most providers conduct telemedicine visits without any previous training in this area, which leaves them as novices when it came to webside manner," Dr. Naik said. "And so we're all starting from the same page, whether we were already practicing clinicians that had 20 years of experience or if we were first-year medical students."

Just as bedside manner encompasses much more than one's appearance in person, webside manner transcends how one looks on camera, he noted. It's also about empathy and understanding the totality of

the encounter.

"This is, I think, where a lot of people have difficulties with telemedicine. They try to take what they do in person and move it, en block, into the virtual realm," Dr. Naik said. "We can't do that. We have to teach a different set of skills to actually care for a patient."

The trainings began with a flipped classroom module, which was delivered remotely and included basics in lighting and camera angles, as well as some of the medicolegal aspects of telemedicine, such as the Ryan Haight Act - the federal prohibition on form-only online prescribing of controlled substances, which has been relaxed during the pandemic.

They were then backed up by in-person experiential learning involving virtual visits with simulated patients. These were followed by hour-long debriefs based on recordings of the visits. Of course, now the trainings are done entirely online.

"Being able to watch yourself on camera taking care of a patient is awful and awesome at the same time," Dr. Naik said. "We have to get used to seeing ourselves on camera because that's the only way we get comfortable being on camera."

6 quick tips

Dr. Naik cited several fundamentals physicians should observe for video visits:

- Put yourself in the center of your frame. You are the focal point, not your background.
- Position lighting to reduce glare and spotlighting. You want uniform lighting that allows the patient to see your face.
- Eliminate background items that could distract the patient.
- Make sure you are HIPAA-compliant by confirming anyone else in your room is necessary to the visit and approved by the patient.
- Confirm the patient's location to ensure you have the proper licensure.
- Ask the patient to rearrange their furniture, lighting or body position to give you a better view of what you need to see to do an exam and what you need to know about their home environment.

WHAT DOCTORS CAN DO TO THWART CYBERCRIMINALS AS 2020 CLOSES

By: Andis Robeznieks, AMA Senior News Writer

A resurgence of COVID-19 combined with the flu season will add up to a growing reliance on digital tools in an effort to provide patients care while letting them stay in their homes.

To help physicians and others prepare, the AMA and the American Hospital Association (AHA) have developed a resource that includes recommended steps needed to bolster network security and patient privacy efforts.

The resource, "Looking Forward: Technology Considerations for the Rest of 2020," builds on and updates a previous AMA-AHA joint resource "What Physicians Need to Know: Working from home during the COVID-19 pandemic."

"Privacy and security are distinct, but closely interrelated," the resource says. "It is not enough for medical practices and hospitals to invest in one but not the other. Fortunately, the concepts are mutually reinforcing, meaning that many actions that are taken to bolster security of patient information will also better protect the privacy of that information."

While fighting to contain the pandemic, physician practices and hospitals have also had to combat cybercrime on these three fronts.

A "dramatic" rise in phishing campaigns. Emails promising needed equipment that was in short supply - from N95 masks to ventilators - flooded the health care sector. But, behind these empty promises were malware and malicious links.

Targeted attacks on vulnerable links between patients and physicians. Cyber criminals struck the virtual private networks and other cloud services that were brought into use for telehealth and medical remote-monitoring devices.

Ransomware attacks are a growing

concern. These can be particularly harmful because they can disrupt patient care, disable critical systems, interrupt revenue flow, necessitate the installation of expensive remedies, and put institutions and practices at risk for legal and regulatory exposure and reputational harm.

Strengthen network connections

While enhanced interconnectivity can benefit patients by supporting integrated care, it also makes systems especially vulnerable as a successful attack on an individual network component can have rippling negative impacts among physician offices, hospitals, ambulatory surgery centers, laboratories, pharmacies and imaging centers.

The resource's section on security includes several questions that physicians and others need to answer. These are among them.

Are there network components that may create vulnerabilities? These may include personal mobile devices or home computers with out-of-date firewall technology.

Are there legacy devices that use Windows 7 as their operating system? Unless an extended security update was purchased, support for Windows 7 expired early this year, meaning no further security updates are forthcoming.

Where is protected health information (PHI) stored? The resource recommends actions be taken if PHI is sent via unencrypted emails or knowingly or unknowingly stored in medical devices or office equipment. Photocopiers, for example, can store thousands of patient records.

Ensure that vendors protect privacy

In an effort to spur use of telehealth at the start of the COVID-19 public health emergency, the U.S. Department of Health and Human Services Office for Civil Rights announced that it would use discretion in enforcing HIPAA privacy and security violations for physicians and hospitals who made a good faith effort to quickly adopt telehealth technology to connect with their patients.

This discretionary period will likely close, however, with the end of the declared emergency, so the resource advises physicians to start planning now on how they will come into HIPAA compliance if they are not already.

On both the cybersecurity and privacy fronts, a strong business associate agreement (BAA) with vendors is key and the BAA should match the level of risk associated with the vendor's role, amount of data they hold, the sensitivity of that data and the vendor's access to it.

"Many physicians do not realize that a telemedicine platform or application may be low-cost or free because the vendor's business model is based on aggregating and selling patients' data," the resource states. "If possible, consult with your legal team to clarify how video, audio, and other data are being captured and stored by the vendor and who has access."

3 INNOVATIVE PROPOSALS EARN FUNDING TO CHANGE RESIDENCY TRAINING

By: Brendan Murphy, AMA News Writer

Projects aiming to better prepare residents for entry to practice, address health inequities and improve residency selection through preference signaling will move forward with funding from the AMA.

The three proposals each will earn $20,000 in funding as winners of the AMA GME Innovation Challenge after being selected as the top project proposals from a group of 25 at the recent AMA GME Innovations Summit.

A "Shark Tank"-style competition, the GME Innovation Challenge received more than 125 submissions, 25 of which were presented at the virtual meeting this month. Five finalists advanced to a Q&A session with leaders in residency education on the event's final day, with the three winning proposals being announced at the conference's conclusion.

"The ideas that were selected reflect the interest people have in addressing those specific areas of graduate medical education - competency-based medical education and preparation for independent practice, health equity and understanding the communities we serve, addressing an increase in applications to residency programs and the anxiety that applicants may feel because of it," said John Andrews, MD, the AMA's vice president for GME innovations.

Improving health outcomes locally

A project proposal submitted by Anita Blanchard, MD, professor of obstetrics and gynecology and associate dean for graduate medical education at the University of Chicago, aims to address heath inequities in the community surrounding the health system.

People who live in the South Side neighborhood surrounding the University of Chicago have life expectancies of up to 20 years fewer than residents in other areas of the city. Dr. Blanchard proposed a plan that would foster resident physician connections with the surrounding community while integrating community needs assessment into the GME curriculum.

The proposal calls for all first-year residents to learn foundational skills in implicit bias, cultural humility and community awareness. Advanced residents will serve as community

champion liaisons to foster meaningful, sustainable partnerships between their GME programs and UChicago Urban Heath Initiative, an organization that fosters robust urban revitalization efforts.

Finding the perfect match

Residency applications are on the rise, complicating matters for residency programs and the medical students applying. A proposal submitted by Jesse Burk-Rafel, MD, an assistant professor of medicine at New York University Grossman School of Medicine, calls for moving to a system that allows applicants to convey the seriousness of their interest to select number of residency programs.

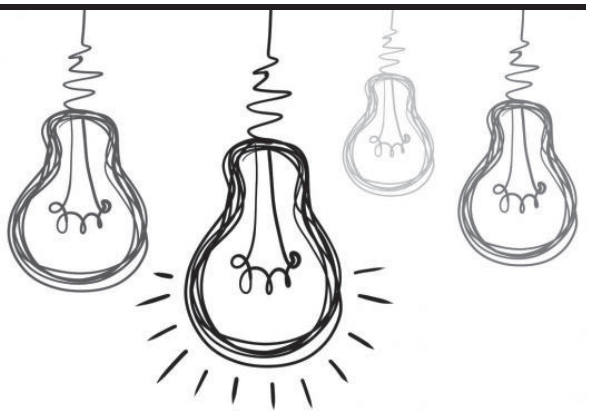
Applicants would get a limited number of "roses", a nod to a famed dating show, to give to programs at the time of submitting their residency application to signal their genuine interest in that program. "Roses" would be limited to a small number, perhaps five, and programs would know by receiving a rose that the applicant had used a scarce resource to indicate their sincere enthusiasm.

Last step before independent practice

A proposal submitted by Rebecca Jaffe, MD, an associate professor in the hospital medicine division at Thomas Jefferson University, looks to add a "pre-attendingship" to the end of residency training.

The proposal would allow graduating residents a final opportunity to integrate knowledge across competencies, encounter attending-level health systems science challenges in a controlled environment, and demonstrate readiness for practice before graduation.

The initiative calls for pre-attendings to go through many of the tasks in their future, such as scheduling room coverage; maximizing safety, quality and productivity; billing for services; and interacting with collaborating health professionals. Supervision would occur at the "oversight" level, including weekly meetings with faculty to incorporate feedback, review performance metrics, and set goals for self-directed learning.



Changing GME

With more than 100 presentations over three days, the GME Innovations Summit was an extension of the AMA's ongoing work to reshape GME. The AMA Reimagining Residency initiative has awarded more than $15 million in grants to institutions that will transform residency training to meet the workforce needs of America's current and future health care system.

JOHN COLOMBO, MD

April 6, 1933 - February 5, 2019

John Colombo, MD of Grosse Pointe, passed away on February 5, 2019 at the age of 85. He peacefully passed surrounded by his wife, Helen Colombo and his daughter, Gina Rimanelli.

A memorial service was held in his honor, Saturday February 16, 2019 at St. Joan of Arc Catholic Church.

Dr. Colombo was born April 6, 1933 in Detroit, son of Lizzie (Matta) and Charles Colombo. After graduating high school he moved to Ottawa to pursue a degree in medicine. He graduated from the University of Ottawa in 1961 as an Ophthalmologist. In 1964 he settled in Grosse Pointe and started his own private practice, East Detroit Ophthalmology. Dr. Colombo rejoined the Macomb County Medical Society and the Michigan State Medical Society in 1993. He retired in at the age of 83 in 2016. While in medicine he held the title of Chief of Staff at Holy Cross Hospital.

During his life, Dr. Colombo was an avid boater and motorcycle rider. He was active in the Grosse Pointe Power Squadron and was a full certificate past commander in 1984.

He is survived by his wife of 41 years and their daughter, Gina Rimanelli, her husband Anthony and their 3 children, Gianna, Rocco, and Sienna.

Dr. Colombo lived a full life and while he will be missed by many he will be remembered for his charismatic smile, positive attitude and his compassion.

Get vaccinated. Get your smartphone. Get started with v-safe.

What is v-safe?

V-safe is a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after you receive a COVID-19 vaccination. Through ***v-safe***, you can quickly tell CDC if you have any side effects after getting the COVID-19 vaccine. Depending on your answers, someone from CDC may call to check on you. And ***v-safe*** will remind you to get your second COVID-19 vaccine dose if you need one.

Your participation in CDC's ***v-safe*** makes a difference—it helps keep COVID-19 vaccines safe.

How can I participate?

Once you get a COVID-19 vaccine, you can enroll in ***v-safe*** using your smartphone. Participation is voluntary and you can opt out at any time. You will receive text messages from ***v-safe*** around 2pm local time. To opt out, simply text "STOP" when ***v-safe*** sends you a text message. You can also start ***v-safe*** again by texting "START."

How long do v-safe check-ins last?

During the first week after you get your vaccine, ***v-safe*** will send you a text message each day to ask how you are doing. Then you will get check-in messages once a week for up to 5 weeks. The questions ***v-safe*** asks should take less than 5 minutes to answer. If you need a second dose of vaccine, ***v-safe*** will provide a new 6-week check-in process so you can share your second-dose vaccine experience as well. You'll also receive check-ins 3, 6, and 12 months after your final dose of vaccine.

Is my health information safe?

Yes. Your personal information in ***v-safe*** is protected so that it stays confidential and private.*

*To the extent ***v-safe*** uses existing information systems managed by CDC, FDA, and other federal agencies, the systems employ strict security measures appropriate for the data's level of sensitivity. These measures comply, where applicable, with the following federal laws, including the Privacy Act of 1974; standards enacted that are consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Federal Information Security Management Act, and the Freedom of Information Act.

v-safe℠
after vaccination health checker

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

Sign up with your smartphone's browser at
vsafe.cdc.gov

OR

Aim your smartphone's camera at this code

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Sustaining the Well-Being of Healthcare Personnel during Coronavirus and other Infectious Disease Outbreaks

The extreme stress, uncertainty, and often difficult medical nature of global infectious disease outbreaks, such as Coronavirus (COVID-19), require special attention to the needs of healthcare personnel. Taking care of yourself and encouraging others to practice self-care sustains the ability to care for those in need.

> Taking care of yourself and encouraging others to practice self-care sustains the ability to care for those in need.

Challenges for Healthcare Personnel During Infectious Disease Outbreaks

- **Surge in care demands.** Many more people present for care, while increased healthcare personnel are sick or caring for family.
- **Ongoing risk of infection.** Increased risk of contracting dreaded illness and passing it along to family, friends, and others at work.
- **Equipment challenges.** Equipment can be uncomfortable, limit mobility and communication, and be of uncertain benefit; shortages occur as a result of increased, and sometimes unnecessary, use.
- **Providing support as well as medical care.** Patient distress can be increasingly difficult for healthcare personnel to manage.
- **Psychological stress in the outbreak settings.** Helping those in need can be rewarding, but also difficult as workers may experience fear, grief, frustration, guilt, insomnia, and exhaustion.

Strategies for Sustaining Healthcare Personnel Well-Being

- **Meet basic needs.** Be sure to eat, drink, and sleep regularly. Becoming biologically deprived puts you at risk and may also compromise your ability to care for patients.
- **Take breaks.** Give yourself a rest from tending to patients. Whenever possible, allow yourself to do something unrelated to work that you find comforting, fun, or relaxing. Taking a walk, listening to music, reading a book, or talking with a friend can help. Some people may feel guilty if they are not working full-time or are taking time to enjoy themselves when so many others are suffering. Recognize that taking appropriate rest leads to proper care of patients after your break.
- **Connect with colleagues.** Talk to your colleagues and receive support from one another. Infectious outbreaks can isolate people in fear and anxiety. Tell your story and listen to others'.
- **Communicate constructively.** Communicate with colleagues clearly and in an optimistic manner. Identify mistakes or deficiencies in a constructive manner and correct them. Compliment each other — compliments can be powerful motivators and stress moderators. Share your frustrations and your solutions. Problem solving is a professional skill that often provides a feeling of accomplishment even for small problems.
- **Contact family.** Contact your loved ones, if possible. They are an anchor of support outside the healthcare system. Sharing and staying connected may help them better support you.
- **Respect differences.** Some people need to talk while others need to be alone. Recognize and respect these differences in yourself, your patients, and your colleagues.
- **Stay updated.** Rely on trusted sources of information. Participate in meetings to stay informed of the situation, plans, and events.
- **Limit media exposure.** Graphic imagery and worrisome messages will increase your stress and may reduce your effectiveness and overall well-being.
- **Self check-ins.** Monitor yourself over time for any symptoms of depression or stress disorder: prolonged sadness, difficulty sleeping, intrusive memories, hopelessness. Talk to a peer, supervisor, or seek professional help if needed.
- **Honor your service.** Remind yourself that despite obstacles or frustrations, you are fulfilling a noble calling — taking care of those most in need. Recognize your colleagues — either formally or informally — for their service.

Medical Records of Retired Physicians

Patients looking for their medical records from retired physicians frequently contact the MCMS. If you are retired or will be retiring shortly, please contact the MCMS at 877-264-6592 or email macombcms@gmail.com and let us know how patients can retrieve their records. If the records have been destroyed, please inform us of that also so we can note our database accordingly. *Thank you!*

November/December 2020

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Paul Wojo (D), District 9