Macomb

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Changes to Immigration Policy are Necessary to Fight COVID-19

By: Kate McCarroll, Attorney at Kerr Russell

IN A RECENT SURVEY, THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA) ESTIMATED THAT 30% OF PHYSICIANS AND 17% OF REGISTERED NURSES IN THE UNITED STATES WERE BORN OUTSIDE OF THE COUNTRY. ABOUT 23% OF HOME HEALTH PROVIDERS AND NURSING AIDES ARE IMMIGRANTS, AS ARE 20% OF PHARMACISTS.

Never has our reliance on foreign health care workers been as apparent as during the COVID-19 pandemic. Physicians, nurses, and other healthcare professionals in the U.S., hailing from all parts of the globe, have served on the front lines fighting the pandemic, caring for patients, and tirelessly pursuing effective treatments, while putting their personal safety at risk.

While they serve our communities, many foreign-born physicians and nurses face lengthy delays in obtaining lawful permanent resident status (green cards) - sometimes waiting more than ten years. Green cards are numerically limited, and there are many more applicants than there are available green cards, resulting in significant backlogs. Healthcare workers born in India, China and the Philippines have the longest wait times, as those countries are the birthplace of a majority of U.S. green card applicants.

While they wait for their turn in the green card "line," healthcare workers remain in non-immigrant visa status (e.g. H-1B), which poses significant limitations on employment. For example, a foreign physician working in an area with few COVID-19 cases cannot simply travel to another state to lend assistance where she is needed. She cannot take a shift at another hospital in the same area where she works. She cannot work full-time hours to help with the pandemic, if the non-immigrant visa filing indicated she would be part-time. Each of these seemingly minor changes in employment require a filing with the U.S. Citizenship and Immigration Service, a tedious and expensive undertaking that delays and healthcare professionals from working where they are critically needed. When an individual holds a green card, she has flexibility in the work location, position, hours worked, and employer, allowing healthcare professionals to answer the call to serve where needed, unimpeded.

On April 30, 2020, a bipartisan group of U.S. Senators introduced a bill (The Healthcare Workforce Resilience Act) to strengthen the U.S. healthcare workforce and improve healthcare access during the COVID-19 crisis. The bill would "recapture" up to 25,000 green cards for nurses and 15,000 for physicians from a pool of unused green cards that Congress previously authorized. In addition, the bill contains the following provisions:

- Unlike regular green card processing, the foreign worker's country of birth will not matter. Green cards will be given in order of the individual's priority date, which is her place in the green card line.
- Expedited processing of qualifying cases will be required.
- The filing period for green card applications under the Act will expire 90 days after the President terminates the COVID-19 emergency declaration.
- Employers who have employees who will complete the process overseas must attest that the foreign national will not displace a U.S. worker.

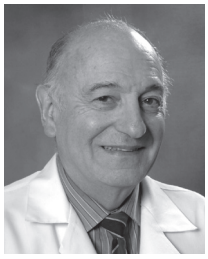
The Healthcare Workforce Resilience Act has gained widespread support. On May 8, a bipartisan group of representatives introduced a corresponding bill in the House. The American Hospital Association (AHA), American Organization for Nursing Leadership (AONL), American Medical Association (AMA), U.S. Chamber of Commerce, and numerous other organizations have expressed support. While many are optimistic that the bill will be enacted into law, it is still in the early stages of the legislative process. Many details, such as who would be eligible under the bill, how quickly the green cards would be exhausted, and the timing of the program, are still unknown.

Given our immediate and urgent need for available healthcare professionals in regions hit particularly hard by COVID-19, Congress should act quickly to pass the bill and send to President Trump for signature, so that its provisions can be implemented.

Kate McCarroll helps lead Kerr Russell's Immigration Law group. She has extensive experience in employment-related immigration law, including I-9 compliance and assisting corporations with government audits. Kate has also handled immigration matters involving family-based immigration and asylum proceedings and has expertise in the specialized area of physician immigration. More information about Kate and the firm can be found at www.kerr-russell.com.

Since 1874, Kerr Russell has been one of Detroit's leading law firms. As trusted partners to our clients, we provide legal solutions that are prompt, accurate, and economical in almost every area of the law.

FLINT PHYSICIAN BOBBY MUKKAMALA, MD, BECOMES PRESIDENT OF MICHIGAN STATE MEDICAL SOCIETY



By: Adrian J. Christie, MD; Paul Bozyk, MD; Donald R. Peven, MD;

On April 27 the Michigan State Medical Society (MSMS) formally welcomed S. Bobby Mukkamala, MD, a Flint otolaryngologist, as the new president of the Society. Doctor Mukkamala served the last year as president-elect of the Society.

Doctor Mukkamala, a board-certified otolaryngologist-head and neck surgeon who earned his medical degree from the University of Michigan Medical School, is past chair of the board of the Community Foundation of Greater Flint. He is also chair emeritus of the Crim Fitness Foundation. He and his wife, Nita Kulkarni, MD, have been instrumental in the revitalization of the downtown Flint area that is their home.

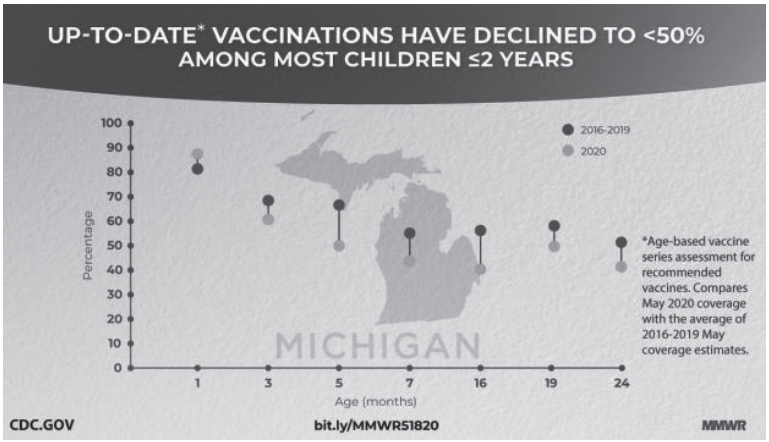
"The Michigan State Medical Society has always done an incredible job of advocating on behalf of physicians in an effort to help us better serve our patients and our communities," Doctor Mukkamala said. "That's always been important work, but it unquestionably takes on a new weight in these trying times. Now more than ever, Michigan's physicians and patients need a strong, consistent voice working on their behalf, and I'm honored, humbled, and ready to take on that charge and carry our Society's mission forward."

In addition to his past term as president-elect, Doctor Mukkamala recently completed three years of leadership service as the chair of the MSMS Board of Directors, which provides operations oversight for the medical society headquartered in East Lansing. He also serves on the American Medical Association Board of Trustees and is a past recipient of the of the organization's "Excellence in Medicine" Leadership Award. Doctor Mukkamala is a past president of the Genesee County Medical Society and currently serves on their board.

MICHIGAN'S PEDIATRIC IMMUNIZATION COVERAGE DECLINES DURING THE COVID-19 PANDEMIC

On May 18, CDC published an article in Morbidity and Mortality Weekly Report (MMWR) showing Michigan's decline in pediatric immunization coverage during the COVID-19 pandemic according to data from the Michigan Care Improvement Registry (MCIR).

Unfortunately, there have been declines in coverage among most children at milestone ages in May 2020 compared to previous May estimates. From January through April 2020, the number of non-influenza vaccine doses given to children aged <18 years decreased 21.5% compared to the average for the same period in 2018 and 2019, and the number of doses given to children aged <2 years decreased 15.5%. Up-to-date vaccinations have declined to <50% among most children aged ≤2 years.



Among children aged 5 months, up-to-date status declined from approximately two-thirds during May 2016-2019 to less than half (49.7%) in May 2020. Additionally, coverage for the May 2020 child cohorts of children at ages 1, 3, 5, 7, 16, 19, and 24 months was lower for Medicaid-enrolled children compared with children not enrolled in Medicaid. Please follow safe measures to continue to bring children in for vaccine appointments during this crucial time, especially those aged less than 2 years when protection against vaccine-preventable diseases is so crucial.

MSMS PRACTICE SOLUTIONS PARTNERS WITH DRFIRST TO MAKE TELEHEALTH AVAILABLE TO MICHIGAN PHYSICIAN PRACTICES TO HELP PREVENT SPREAD OF CORONAVIRUS

The Michigan State Medical Society and DrFirst are collaborating to make telehealth technology available to physician practices, to help prevent the spread of COVID-19.

DrFirst is a pioneer in technology, support, and services that connect people at touchpoints of patient care.

DrFirst's Backline care collaboration platform includes a telehealth feature that allows physicians to initiate telehealth visits with

patients in a secure manner that protects patients' private health information. Patients do not need to download an app, access a patient portal, or undergo a cumbersome registration process.

Congress, the White House, and public health experts point to the critical role of telehealth for patient care during the coronavirus pandemic. Telemedicine allows clinicians to treat patients without exposing healthcare workers and other patients to the coronavirus.

"It's important that physicians have access to telehealth solutions that are quick and easy to implement, simple to use, and protect private health information," said S. Bobby Mukkamala, MD, President, Michigan State Medical Society. "We are partnering with DrFirst so that physician practices in Michigan can implement telehealth right away, to help provide their patients with continuity of care and reduce the risk of exposure."

Backline is used to improve care collaboration in nearly every setting, including physician practices, hospitals, long-term care facilities, emergency medical services, hospices, and pharmacies. Healthcare providers use Backline's HIPAA-compliant secure messaging and telehealth capability to confer with other clinicians.

"DrFirst is committed to keeping patients and healthcare providers safe," said G. Cameron Deemer, president of DrFirst. "Telehealth and other strategic uses of technology can be critical defenses against the COVID-19 pandemic. We stand ready to work with the Michigan State Medical Society and physician practices to help protect their patients and staff from exposure."

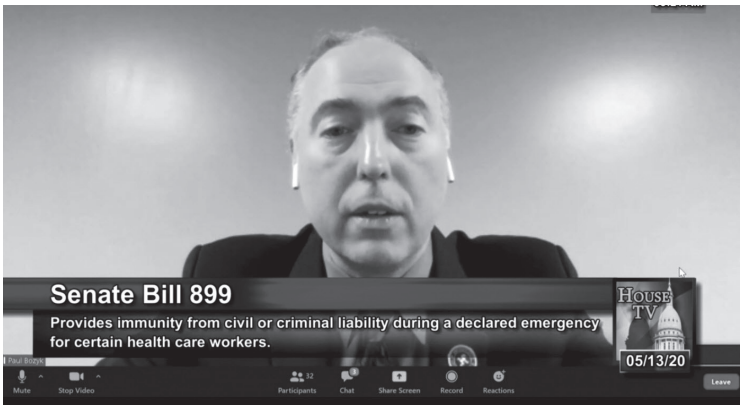
About MSMS Practice Solutions

MSMS Practice Solutions is a practice management program providing discounts on various products and services. Available only to MSMS members, carefully selected partners are an excellent value that may help physicians and their practices succeed in the ever-changing medical practice environment. When contacting any of the MSMS Practice Solutions partners, be sure to identify yourself as an MSMS member to ensure the best service.

MSMS TESTIFIES ON MEDICAL LIABILITY PROTECTIONS

Paul D. Bozyk, MD (Oakland), member of the Michigan State Medical Society (MSMS) Board of Directors, and MSMS Legal Counsel, Kathleen Westfall, JD, testified on behalf of MSMS before the House Committee on Judiciary on May 13, 2020, in support of Senate Bill 899, introduced by Senator Michael MacDonald (R-Macomb Township). This legislation, which seeks to codify and clarify immunity protection for health care professionals acting in response to the current novel coronavirus (COVID-19) pandemic, is currently under debate by the Michigan Legislature. Your voice is needed to ensure the Legislature understands the importance of protecting physicians from liability claims arising from the COVID-19 response.

Michigan's physicians and other health care providers have responded to the call to protect the health and well-being of the people of Michigan due to the novel COVID-19 pandemic. They are at the forefront caring for patients throughout this pandemic, despite risks to their own health and safety and viability of their medical practices and facilities. Passage of Senate Bill 899 (S-2) is necessary to safeguard physicians and other health care providers on the frontline of this new, novel virus, as they treat patients and make other treatment decisions in compliance with the orders and guidance of governmental authorities.



If passed, Senate Bill 899 will achieve the following:

- Make clear immunity begins retroactive to March 10, 2020 and continues for the duration of the COVID-19 state of emergency or state of disaster or through September 30, 2020, whichever is later.
- Confirm that immunity applies to criminal as well as civil liability.
- Clarify the immunity applies not only to licensed health care professionals, but also to students, retirees, and other unlicensed health care professionals that have provided health care services in support of the State's response to this virus.

MSMS is also advocating for a bill amendment to expressly clarify that decisions made regarding the postponement, cancellation, or rescheduling of any health care services, as a result of government COVID-related directives, are covered by the immunity provisions in the bill.

Continued on next page

HELPING PATIENTS CREATE THEIR DIABETES EMERGENCY KITS

If your patients are new or resistant to the idea of diabetes emergency kits, they can learn more by watching a video of "how to pack your diabetes emergency kit" or download written plans (available in English and Spanish): Diabetes Emergency Plan (http://www.mydiabetesemergencyplan.com/patients). They can learn how to make a Patient Preparedness Plan and how to safely store insulin.

For more information, patients can visit www.Michigan.gov/Diabetes. To find nearby DSMES offerings, patients can visit www.MiHealthyPrograms.org.

Medication Assistance During the COVID Emergency:

During the COVID-19 pandemic drug companies are stepping up to provide relief for those already using their medication.

- The American Diabetes Association has gathered many resources and posted them on their website at Insulinhelp.org. Scroll to the bottom of the page. The American Association of Clinical Endocrinologists and the American College of Endocrinology also had resources that list help by medication and can be found at Prescription Help.
- To help locate affordable healthcare and medication patients can visit NeedyMeds.org.
- Patients can compare pricing for their medications at pharmacies nearest them by visiting GoodRx.com.
- Other ways for patients to save:

  - Check with their insurance to see if mail order is available. This will minimize exposure with picking up medications at the pharmacy.

  - Check with their insurance companies to see if they can get a 90-day supply instead of 30-days to minimize trips out into the community.

- For more information, patients can visit www.Michigan.gov/Diabetes.
- To find nearby DSMES offerings, patients can visit www.MiHealthyPrograms.org.

MSMS ANNOUNCES NEW WEBSITE TO GET PPE FOR PHYSICIAN PRACTICES

The Michigan State Medical Society, in partnership with Foresight Group, announced the launch of a new website, http://MSMS.org/PPESupplies, to get personal protective equipment and other supplies for Michigan's physician practices. The website will allow 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

FCC AWARDS MCLAREN $626,328 IN FUNDING FOR TELEHEALTH SERVICES

McLaren Health Care has been awarded $626,328 in funding for expanded telehealth services from the Federal Communications Commission's (FCC) COVID-19 Telehealth Program. McLaren is one of 30 health care providers nationwide to be approved for this special allocation as of April 30, 2020.

This FCC program provides immediate support to eligible health care providers responding to the pandemic by fully funding their telehealth platform services and equipment necessary to provide critical connected care services. The funding allows for 12 of McLaren's hospitals across Michigan to enhance telehealth connectivity between providers and patients statewide.

McLaren first launched its consumer-based telehealth service, McLarenNow, in March of 2019. Through McLarenNow, Michigan residents can virtually connect with a board certified physician, 24/7, through their computer or smart phone. The service has expanded to include a clinic-to-clinic platform, facilitating virtual visits between McLaren patients and their own specialty and primary care providers.

Since mid-March, when COVID-19 cases in Michigan began to multiply, McLaren's telehealth platform has grown exponentially. To meet a growing need, McLarenNow began providing COVID-19 screenings in addition to virtual visits for urgent care needs.

"We went from seeing 8 to 10 patients a day on our McLarenNow platform to seeing as many as 50 patients per day in April," noted Cheryl Ellegood, Vice President of Service Lines at McLaren. "Our clinic-to-clinic telehealth consults went from 300 in March to 14,000 in April."

This growth was also influenced by the CMS expansion of telehealth benefits, allowing physicians to provide virtual visits to their patients in their homes. CMS also removed the restriction of only paying for patient visits in designated rural locations. Once these measures were put in place to reduce the risk of COVID-19 exposure, there was a huge demand for telehealth access from physicians on McLaren's medical staffs. As a result, McLaren's telehealth program onboarded 545 employed physicians and an additional 55 members of its ACO in April, with more slated in May.

It has been intense work, including getting the appropriate licensing, obtaining equipment, and then training providers on use of the platform, proper documentation and coding for reimbursement.

"The accelerated growth we have seen in our telehealth program from March 5 to May 1 is equivalent to the growth we were forecasting over a two-to-three year period of time," Ellegood emphasized. "We are very appreciative of receiving this FCC allocation, as it allows us to continue our telehealth outreach. This is a trend that will continue to gain traction. Physicians and patients have truly bought into telehealth as a means of accessing care."

MCLAREN MACOMB FIRST IN MACOMB COUNTY TO PERFORM WATCHMAN PROCEDURE FOR STROKE PREVENTION

McLaren Macomb, through its comprehensive cardiology program in the Mat Gaberty Heart Center, is the only hospital in Macomb County to offer the Watchman device for stroke prevention for patients with non-valvular atrial fibrillation, an irregular heart rhythm. The device is an alternative for patients prescribed with a long-term anticoagulant, a blood thinning medication.

A minimally invasive procedure performed in the cardiac catheterization lab, once deployed the Watchman device closes off the left atrial appendage, a small, non-vital opening in the heart's left atrium muscle wall. For patients with non-valvular atrial fibrillation, blood can pool in this appendage, increasing the chances of clots forming and traveling through the blood stream to the brain, potentially leading to a life-threatening ischemic stroke.

The Watchman safely and effectively seals the opening to the appendage, not allowing blood to pool and potentially create troublesome clots. This can lead to patients on long-term anticoagulation therapy to no longer require the blood thinning medication, which can carry risks of complications.

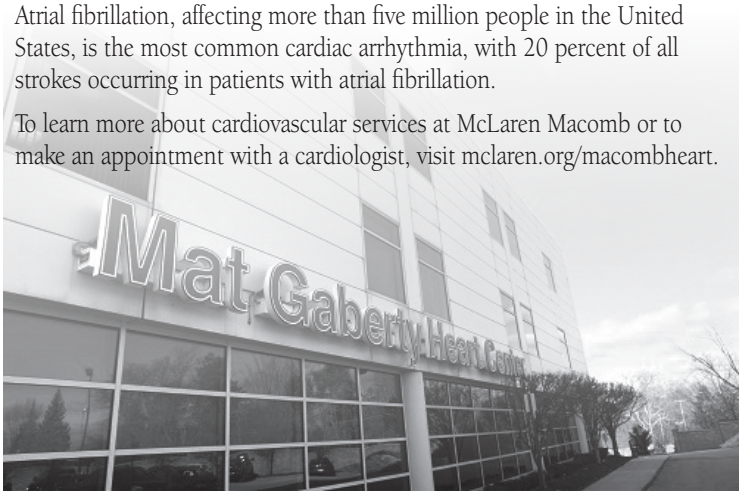
"The Watchman device is a great alternative for atrial fibrillation patients who are unable to take anticoagulants to prevent strokes," said Dr. M. Cameron Willoughby, a cardiac electrophysiologist with McLaren Macomb. "We are enthusiastic to be able to provide this service for the patients in our community."

The device is implanted via a catheter inserted into the groin and tunneled up to the heart and the left atrial appendage for deployment. The Watchman was approved by the FDA after extensive clinical trials, which showed strong evidence that the device can be safely implanted and reduce the chances of stroke in eligible patients.

Patients with atrial fibrillation live with a greater risk for stroke. The non-valvular form of atrial fibrillation is caused by conditions such as high blood pressure or an overactive thyroid rather than a faulty heart valve. Blood thinning medications help prevent the formations of blood clots in patients' bloodstreams.

Atrial fibrillation, affecting more than five million people in the United States, is the most common cardiac arrhythmia, with 20 percent of all strokes occurring in patients with atrial fibrillation.

To learn more about cardiovascular services at McLaren Macomb or to make an appointment with a cardiologist, visit mclaren.org/macombheart.



Henry Ford Macomb Hospital

EMBRACING A NEW NORMAL AT HENRY FORD HEALTH SYSTEM

Full slate of services driven by new health, safety measures set to resume.

Henry Ford Health System is moving to resume a full slate of services in the coming weeks with new measures in place at all of its facilities to protect the health and safety of patients, visitors and team members.

The measures reflect the new normal in the midst of the coronavirus pandemic.

As services are ramped up as part of a phasing in strategy that emphasizes safety, patients will see changes as they arrive for a radiology screening, surgery or in-person doctor's appointment:

- All patients, visitors and team members are being screened for COVID-19 symptoms before entering the building. This includes a temperature check. Those who show possible signs of illnesses are referred for proper medical care.
- Masks are always to be worn by patients, visitors and team members. Henry Ford will provide a mask for those who need one upon entry.
- Six-foot social distancing guidelines are in place for waiting, seating and lobby areas. Elevators are limited to the number of riders that can be accommodated safely. Floor markings indicate where patients should stand in the elevators.
- Visitor restrictions continue.
- Patients scheduled for a surgery or some procedures are tested for the coronavirus.
- All facilities are undergoing rigorous disinfection and maintaining frequent cleaning schedules.

The measures apply across Henry Ford's vast network of hospitals, outpatient medical centers, pharmacies, dialysis locations, retail eye care centers and other services in southeast Michigan and Jackson County.

Senior leaders say the safety measures and phasing in strategy are the result of careful and deliberate planning to minimize the potential spread of the coronavirus.

"The safety and well-being of our patients, visitors and team members have always been our most important priority," says Wright Lassiter III, Henry Ford's president and CEO. "We have strived to do everything possible to make them feel safe when they come into our facilities to receive care or to provide care."

As more services become available, Lassiter reassured patients that they can "expect to receive the same high-level care experience they are accustomed to."

Phasing-In Approach

While the focus was on COVID-19 patients, Henry Ford was prudent in continuing to provide patient care services in a limited or reduced way throughout the pandemic. Most patient appointments were done remotely by video through Henry Ford's electronic health record patient portal MyChart. Video visits soared to 10,000 a week as patients embraced the option for interacting with their doctor or specialist from the comfort of their home.

Today, patient appointments continue to be managed virtually, though arrangements are under way to prioritize in-person appointments for patients based on severity of illness. More medical centers plan to resume full operations soon, and with that will come extended hours for the convenience of patients.

All nine Henry Ford emergency departments have continuously remained open as did urgent care centers. Patients are advised not to delay seeking immediate care for life-threatening situations such as chest pain, stroke and asthma attacks.

Henry Ford Maplegrove Center, a substance abuse facility for adolescents and adults, has started providing residential and detox services for a limited number of inpatients. For social distancing, all patient rooms are now private. Four Henry Ford Optimeyes super vision centers in Dearborn, Sterling Heights, Troy and West Bloomfield remain open with additional retail eye care locations scheduled to welcome back patients in early June.

Bob Riney, president of Healthcare Operations and chief operating officer, says planning for the health system's recovery began weeks ago at the first sign of coronavirus cases starting to stabilize and trend downward.

"We were very thoughtful in our planning for re-emerging from this crisis," he says. "We developed a standardized approach that requires certain criteria to be met before a site resumes their full operations. Our guiding principle, like everything we do, is keeping our patients and our team members safe."

It's all part of the Henry Ford Promise to reassure the health and safety of patients.

Riney says the safety practices are likely to continue until the development of a vaccine to protect against COVID-19.

"We're all adjusting to this new normal and it's important for all of us not to let our guard down," he says. "We'll continue to assess what's best for our patients based on science and what keeps everyone who works or comes into our buildings the safest."

During its planning process, the health system also took steps to help patients who are facing economic hardship due to the pandemic and worry about mounting medical bills. Financial relief options are available through Henry Ford Bill Pay and collection practices have been suspended.

Surgery Leads the Re-Emergence

Since the pandemic's onset, Henry Ford performed only a limited number of surgeries, prioritizing life-threatening and critical procedures. This resulted in about 8,000 procedures being postponed. On April 17, the health system resumed time-sensitive surgeries and procedures for certain medical conditions like heart disease and cancer and spinal injuries.

Since then, surgery departments created a tiered approach for rescheduling the 8,000 procedures based on conversations between surgeons, nurses

and their patients and assigning an urgency or priority score to each case. Those procedures are all expected to be rescheduled by the end of June, says Adnan Munkarah, MD, executive vice president and chief clinical officer.

Some cases are being scheduled for Saturdays, even Sundays when necessary.

"We never stopped performing live-saving surgeries for those who needed it the most," Dr. Munkarah says. "What we're finding now is that a condition that wasn't considered time sensitive or urgent in March has now become more urgent. At the same time, we have new patients coming in with conditions that have to be scheduled."

Dr. Munkarah cited a recent heart transplant, two liver transplants and multiple craniotomies to highlight the expertise and complexity of surgeries performed at Henry Ford Hospital, a Level 1 trauma center.

As part of the new safety practices, all surgery patients undergo COVID-19 testing prior to their procedure. Results are returned in just a few hours. To date, all surgery patients have tested negative. In addition, pre-op and post-op surgery areas have been revamped to honor social and physical distancing.

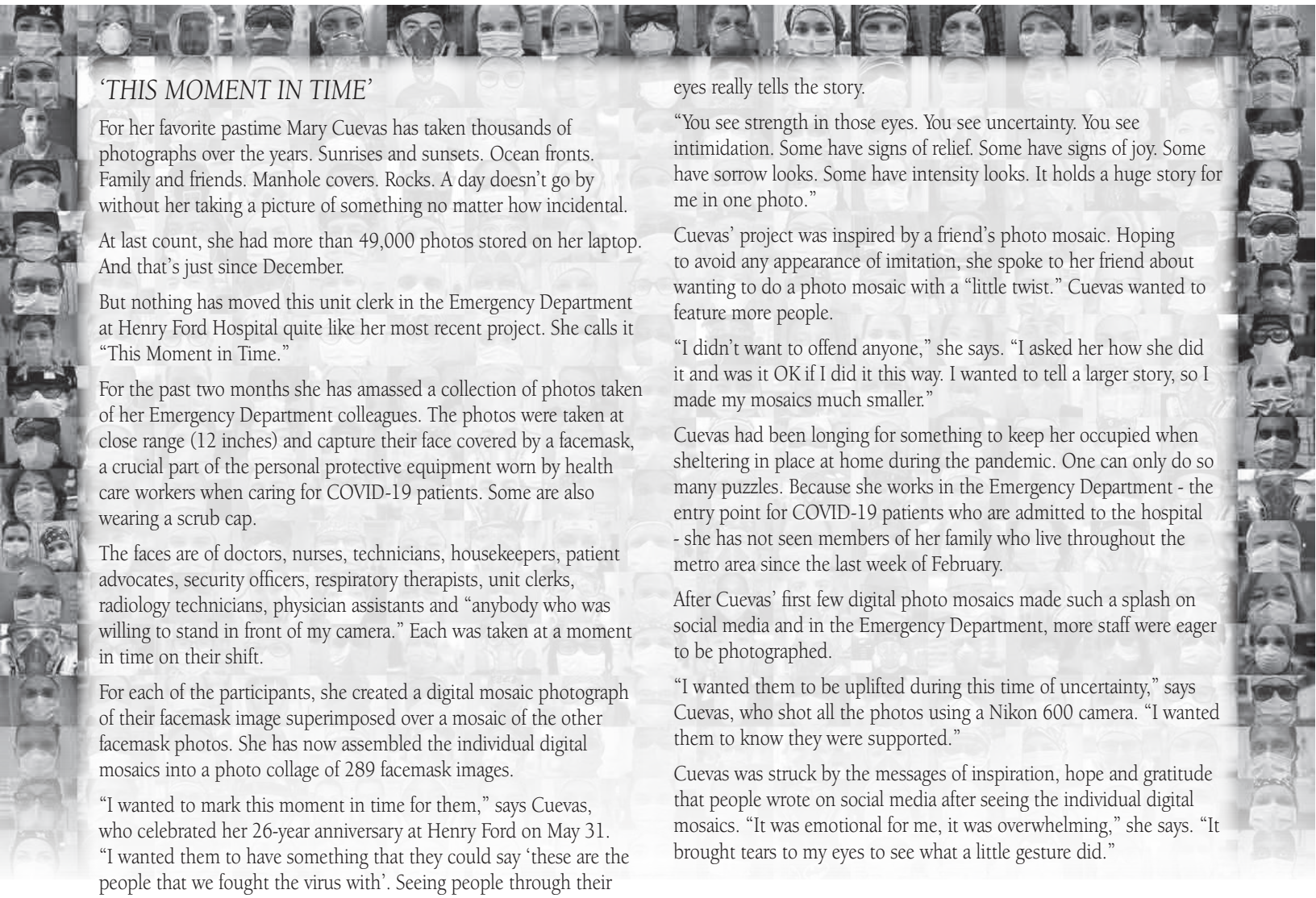
Operating rooms by their very nature are highly sterilized areas and patients can take comfort in that, Dr. Munkarah says.

"Our teams are prepared," he says. "Other than the physical distancing and testing, patients won't notice any other major changes."

Henry Ford's re-emergence continues to unfold, Riney believes the "prudent and thoughtful approach" taken to manage the pandemic well-positions the health system moving forward.

"We've been open and operational throughout this crisis and that's a reflection of our entire workforce," he says. "We're very proud of our frontline team members for their courage and resilience working under trying conditions. The support from the community has been overwhelming and we're so grateful for the donations of food, PPE supplies, cards, well wishes and monetary contributions.

"This pandemic has tested us in many significant ways, but we have weathered this storm. We are ready for the new normal and what that brings ahead."



'THIS MOMENT IN TIME'

For her favorite pastime Mary Cuevas has taken thousands of photographs over the years. Sunrises and sunsets. Ocean fronts. Family and friends. Manhole covers. Rocks. A day doesn't go by without her taking a picture of something no matter how incidental.

At last count, she had more than 49,000 photos stored on her laptop. And that's just since December.

But nothing has moved this unit clerk in the Emergency Department at Henry Ford Hospital quite like her most recent project. She calls it "This Moment in Time."

For the past two months she has amassed a collection of photos taken of her Emergency Department colleagues. The photos were taken at close range (12 inches) and capture their face covered by a facemask, a crucial part of the personal protective equipment worn by health care workers when caring for COVID-19 patients. Some are also wearing a scrub cap.

The faces are of doctors, nurses, technicians, housekeepers, patient advocates, security officers, respiratory therapists, unit clerks, radiology technicians, physician assistants and "anybody who was willing to stand in front of my camera." Each was taken at a moment in time on their shift.

For each of the participants, she created a digital mosaic photograph of their facemask image superimposed over a mosaic of the other facemask photos. She has now assembled the individual digital mosaics into a photo collage of 289 facemask images.

"I wanted to mark this moment in time for them," says Cuevas, who celebrated her 26-year anniversary at Henry Ford on May 31. "I wanted them to have something that they could say 'these are the people that we fought the virus with'. Seeing people through their eyes really tells the story.

"You see strength in those eyes. You see uncertainty. You see intimidation. Some have signs of relief. Some have signs of joy. Some have sorrow looks. Some have intensity looks. It holds a huge story for me in one photo."

Cuevas' project was inspired by a friend's photo mosaic. Hoping to avoid any appearance of imitation, she spoke to her friend about wanting to do a photo mosaic with a "little twist." Cuevas wanted to feature more people.

"I didn't want to offend anyone," she says. "I asked her how she did it and was it OK if I did it this way. I wanted to tell a larger story, so I made my mosaics much smaller."

Cuevas had been longing for something to keep her occupied when sheltering in place at home during the pandemic. One can only do so many puzzles. Because she works in the Emergency Department - the entry point for COVID-19 patients who are admitted to the hospital - she has not seen members of her family who live throughout the metro area since the last week of February.

After Cuevas' first few digital photo mosaics made such a splash on social media and in the Emergency Department, more staff were eager to be photographed.

"I wanted them to be uplifted during this time of uncertainty," says Cuevas, who shot all the photos using a Nikon 600 camera. "I wanted them to know they were supported."

Cuevas was struck by the messages of inspiration, hope and gratitude that people wrote on social media after seeing the individual digital mosaics. "It was emotional for me, it was overwhelming," she says. "It brought tears to my eyes to see what a little gesture did."

Cruising DURING THE CORONA PANDEMIC

This story begins with many other stories written in the 1920's and 30's by authors such as Somerset Maugham set in the South Pacific, in countries then named Malaya, Burma, Borneo and Singapore, which excited the imagination of my wife, Mynetta in her early adulthood. A visit to this exotic region was planned as a celebration for her of one of those decade-turning anniversaries which is nowadays more frequently referred to as "better than the alternative".

By: Adrian J. Christie, MD

The evening of March 5, 2020 before leaving Detroit for our South Pacific cruise to Bora Bora planned a year earlier, Mynetta tells me, the way that a wife of 54 years standing is able to do so, that we are cancelling on the advice of our daughter Helen, an MD with a Masters in Public Health. Both she and her husband Jay, a cardiologist by training, work for different pharmaceutical companies which had both cancelled all overseas travel by their employees. I had checked a couple of days previously with our travel agent who advised that even travel insurance would not reimburse for this reason for cancellation and the insurance premiums themselves were prohibitive. Fortunately, we were not traveling to one of the most severely affected countries though the plane ride to Los Angeles carried risk. The experience of the passengers on the Diamond Princess which was quarantined off Yokohama, Japan, in early February, 2020, (nytimes.com, 'We're in a Petri Dish': How a Coronavirus Ravaged a Cruise Ship) had alerted the public to a potential danger of cruises and had a devastating effect on both cruise ship companies and the closely allied airline industry. The positive outcome for us of the Diamond Princess disaster is that quarantining ships had become discredited and passengers suspected or confirmed infected by Coronavirus were now being returned when possible to their countries of origin to be quarantined in them.

On March 6 we completed forms prior to boarding our cruise ship in Tahiti (Papeete) in French Polynesia confirming that we had not recently visited China, Italy or South Korea. Ship's staff then checked our forehead temperatures with sensors, then up the gangway we went.

On March 9 we visited Taipivai Valley in Nuku Hiva, Marquesas Island and viewed spectacular scenery from the interior of a Toyota truck. We also drove past homes and schools in the countryside. Mynetta sat in the front with the driver and later recounted her conversation with him. His wife was a schoolteacher and the chief family bread winner, enabling them to afford better schooling for their own children in Tahiti. I was almost unable to get back on the tender boat to return to the ship because my forehead temperature was above 40 degrees. I had been taking photos distant from the embarkation dock in 85 degrees heat when I was called that we were leaving. I ran back to the dock and was prevented from boarding the tender until I had cooled down. We noticed that same evening the fancy leather menus in the main dining room had been replaced by disposable paper menus. Returning to our cabin we saw a staff member washing down walls and handrails outside cabins. Surfaces of food dispensing areas in all restaurants were now being wiped with sterilizer liquid frequently. Hand sanitizers had been installed everywhere, outside every restaurant and elevator. Even pens used in Trivial Pursuit quizzes were returned for sterilization. The ornate and peaceful library had been closed as there was concern that the books could help transmit the virus.

There were frequent ship announcements reminding passengers to use sanitizers and that the ship was on high alert.

Meanwhile, of course, many of us had internet access. I was surprised to learn that Sky News showed that people arriving at London's Heathrow Airport from Milan had no screening at all, whereas Israel was subjecting everyone returning or flying in from outside Israel to possible isolation of 14 days. Ascension Health where I work in the USA had instructed all physicians or providers who had traveled out of the country to call Occupational Health for clearance prior to returning to the hospital.

On March 11 we visited the island of Rangiroa where some took a glass bottomed boat to observe colorful undersea life. We were taken to a pearl farm and shown the intricate process and skillful labor necessary for encouraging oysters to produce pearls, which were then sorted for size and quality. Just a handful of locals were employed in the production of large numbers of these jewels of the sea to be sold in fancy stores for high prices. There was a shop next to the factory where some fellow travelers splurged, but as luck would have it, the black pearls on display did not appeal to my wife.

On March 12, just as we were headed to Bora Bora, the ship's captain announced at 2 am that the government of French Polynesia had banned all cruise ships from visiting their islands! The ship had altered course and was heading back to Tahiti, our final destination because the governor's wife had testing positive for the virus on returning from a visit to Paris. There the ship moored for 3 days and we visited the main shopping district a few times until it became quite familiar, as it was smaller than many towns in Michigan; Chelsea or Brighton come to mind, but

the ship's captain announced at 2 am that the government of French Polynesia had banned all cruise ships from visiting their islands!

it was sunny and 85 degrees in mid-March. It also had an interesting flower market with grass-skirted models on display. Fortuitously, we had booked a day room at Tahiti Pearl Beach Resort for our last day as we had a 12 hour wait for our midnight return flight home through Los Angeles. Lunching by a tropical beach and pool with blue seas and sky helped to assuage our disappointment on not reaching Bora Bora.

New Members

HEATHER A. CRONOVICH, DO

Emergency Medicine - Board Certified

Medical School: MI State University College of Osteopathic Medicine, 2007. Post Graduate Education: Beaumont Hospital, completed in 2011. Hospital Affiliation: Henry Ford Macomb. Currently practicing at Henry Ford Macomb Hospital, 15855 19 Mile Rd., Clinton Township, MI 48038, ph. 586-263-2300.

PETER P. LOPEZ, MD

General Surgery and Surgical Critical Care - Board Certified

Medical School: University of Illinois College of Medicine, 1990. Post Graduate Education: Henry Ford Hospital, completed in 1991; Rush University Medical College, IL, completed in 1994; Wayne State University, completed in 1999; Jackson Memorial Hospital, FL, completed in 2001. Hospital Affiliations: Henry Ford Macomb, Ascension Providence, Detroit Medical Center. Currently practicing at Surgical Associate of Macomb, 43331 Commons Dr., Clinton Township, MI 48038, ph. 586-263-2320.

ROBERT MARCOTTE, DO

Internal Medicine and Cardiology - Board Certified

Medical School: MI State University College of Osteopathic Medicine, 2011. Post Graduate Education: Botsford Hospital, completed in 2014 and 2017. Hospital Affiliations: Ascension Macomb Oakland, Ascension Providence, Detroit Medical Center. Currently practicing at Cardiovascular Associates, 27177 Lahser Rd., Ste. 103, Southfield, MI 48034, ph. 248-357-1360.

We would also like to welcome the following new Resident members

ASCENSION MACOMB-OAKLAND HOSPITAL

Jelena Arnautovic, DO
Jonattan Eduardo Angulo
Shanelle Arthur, DO
Grace Bay, DO
Anjum Bokhari, DO
Jorawar Singh Brar, DO
Emily Broomell, DO
David W. Bryd, MD
Gregory Byrd, DO
John Childers, DO
Faiza Choudhry, DO
Robert Cieslak
Michael Comer, DO
Sabina Custovic, DO
Nora Dado, DO
Sean Michael Dawes, DO, MPH
Yael Duer, DO
Matthew Dwyer, DO
Dina Marie Fakhouri, DO
Derrick Ferguson, DO
Himaja Gaddipati, DO
Karlee Grace, DO
Harjot Kaur Grover, DO
Priya Gupta, DO
Janessa Haasbeek
Samah Halbouni
John Hanna
Dustin Taylor Harmon, DO
Andrea Lynn Hartford, DO
Mary Caroline Young Imbs, DO
Randy James Ip, DO
Fares Jamal, DO
Melwin Joseph, DO
Kelsee Leigh Jurewicz, DO
Naser Kafeel, MD
Rani Kattoula, DO
Kristen Kenny, DO
Laiba Khaliq
Daniel Kim, DO
Roy Lee, DO
Ashley Nicole Mahabadi, DO
Megan Alyse Mandelbaum, DO
David J. Mansour, DO
Jessica McDaniel, DO
Hasan Mukhtar, DO
Tyler Case Nesmith, DO
Kristine Nixon
Sailokesh Pagadala
Priyanka Pandey, DO
Sara Papple, DO
Shayla Patton, MD, MPH
Jenna Peplinski, DO
Christine Plitcha, DO
Mohammad Ibrahim Qadir, DO
Matthew Raymond Radant, MD
Mindy Raminick, DO
Sreeker Nallo Reddy, DO
Michael Saleh, DO
Nancy Sarmiento, DO
Laura Scott, DO, MS
Brandon Segrest, DO
Vivek Sengupta, DO
Hassaan Siddiqui
Aye Thet, MD
George Yassa
Chase Michael Zeilenga, DO

HENRY FORD MACOMB HOSPITAL

Arsalan Abbasi
Firdhous Abdul Kather
Robert Acho, DO
Frank Adamini
Jeffrey Aguiar, DO
Fayzan Ahmad
Mohammed Alomgir, DO
Sumeet Kaur Aujla, MD
Eduardo Ivan Avena Arevalo, MD
Thomas Bebekoski, MD
James Bindrup
Christopher Borowy, DO
Brooke Burgess, DO
Kayla Busuito, DO
Clarence Cabatu, DO
Kyle Casadei, DO
Philip Soni Chacko, DO
Tara Chandran, DO
Archana Chandrashekar, DO
Saad Salman Chaudhry, MD
Michael Andrew Cole, DO
Nicola M. Colucci, DO
Amanda Rae Connolly, DO
Meghna Dhir, DO
Anthony Peter Di Ponio, DO
Tiffani Doan, DO
Christina Dolores, DO
John Efthyvoulidis
Elisabeth Ekkel, DO
Ahmad Elghoroury, DO
Brian May Feijoo, MD
Derek Foster, DO
Ty Fullmer, DO
Gurinder Gakhal
Brent Geers, DO
Lea Goldman, DO
Vinay Goyal, DO
Richard Grenn
Vishnu Gudimetla
Usman Hamayoun, MD
Nabih Hammoud
Hye Jeong Han
Benjamin Hart, DO
Dawn Hill
Matthew Hillman, DO
Joseph Jabour, DO
Khaled Jamoor
Sarah Jazaerly, DO
Ashish Sripathi Kalakuntla
Sotirios Kalliantasis, DO
Emily Kerby, DO
Nadia Khan
Cameron King, DO
Dhairya Kiri, DO
Han Lam
Kyle Lange, DO
Haley Lehman, DO
Thomas Leitzsch, DO
Steven Leonwicz
Kenneth Lerardi, DO
Abigail Lindberg, DO
Alexandra Loomis, DO
Ana Maria Lozano, DO
Alexander Lu, DO
Joseph Lucido, DO
Erald Lula
David Macon, DO
Anna Malcolm, DO
Katherine Maltester, DO
Hekuran Marevci
Melissa Martinez, DO
Kathleen McClain, DO
Michael McDonald, DO
Kevin Menschel, DO
Jordynn Metcalfe, MD
Gary Mikhjian, DO
Joseph Molina
Saman Movahedi, DO
Laurie Moy, DO
Alexandria Marie Mozzicato, DO
Sharan Mullen, DO
Phillip Nahirniak, DO
Niren Naidoo
Gouthami Nalakonda, MD
Shannon N. Novin, MD
Tomasz Olejnik
Jonathan Olson, DO
Shyamal Pansuriya, DO
Hayk Papukhyan
Hennah Nimesh Patel
Jay Patel
Keval Patel
Neel Patel
Brice Peter, MD
Michael Piatek
Ryan Qasawa, DO
Antonella Racano, DO
David Ragbeer, DO
Swetha Ramireddy
Rita Rehana
Paul Reynolds, DO
John Riley, DO
Jason Rosner
Alan Rupp
Karla Sanchez
Varun C. Sankuratri, DO
David Schmittou
Matthew Schuch, DO
Asim A. Shabbir, DO
Faryal Shaikh
Lovepreet Singh
Jordan Siu
Sara Smith, DO
Michael Sochacki, DO
Ayman Mohamed Suleiman, MD
Kutiba Tabbaa, MD
Taylor Timoteo, DO
Vamshi Vadlapatla
Aleksandra Vidovich, DO
Alyssa Winters, DO
Heather Wortham, DO
Nothando Zibanayi, MD

HOW TO READY PATIENTS NOW SO THEY'LL GET A COVID-19 VACCINE LATER

By: Tanya Albert Henry, AMA Contributing News Writer

Once a winning COVID-19 vaccine emerges from the dozens in development, the only way it will truly be successful is if enough people get the vaccine to create herd immunity.

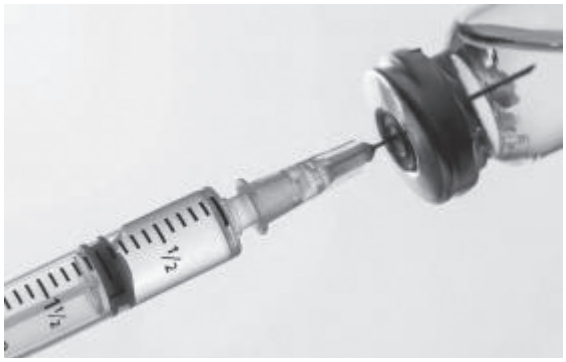
Ensuring that success starts now, authors write in a JAMA Viewpoint essay, "Planning for a COVID-19 Vaccination Program."

The health care system must deliver the vaccine to the public as soon as rigorous testing is completed and the efficacy and safety are established. Patients at the highest risk for complications and disease transmission to others must get the vaccine first if the initial supply doesn't meet demand, the authors wrote.

However, first, it is imperative today to start combating vaccine hesitancy - concerns about vaccine safety, choice and the very need for vaccination. The authors cautioned that vaccine hesitancy may be a major barrier to people getting the vaccine and creating herd immunity.

"The mere availability of a vaccine is insufficient to guarantee broad immunological protection; the vaccine must also be acceptable to both the health community and general public," they wrote. "Depending on varying biological, environmental and sociobehavioral factors, the threshold for COVID-19 herd immunity may be between 55% and 82% of the population."

With a number of patients unable to get the vaccine because of their age, because they are immunocompromised or have another preexisting medical condition, a vaccine refusal rate greater than 10% could mean the nation doesn't reach herd immunity, the authors cautioned. They



noted that recent surveys suggest only three in four people would get vaccinated if a COVID-19 vaccine were available and that only 30% would want to receive the vaccine soon after it is available.

Most recently, a Pew Research Center survey found that 27% of American adults said they would not opt for a COVID-19 vaccine if it were available today.

The authors - pediatricians Sarah Schaffer DeRoo, MD, MA, and Linda Y. Fu, MD, MS at Children's National Hospital, and Natalie J. Pudalov, at the George Washington University School of Medicine and Health Sciences - offered three steps physicians and others can take now to ensure more people get the vaccine when it's available.

Address potential obstacles

Because a vaccine is being developed so quickly and some people mistrust the government's pandemic response, vaccine safety will be a significant concern for patients.

To combat that, transparency will be key. The public needs to hear about the rigorous testing and ongoing monitoring that the vaccine approval process requires, and educational campaigns should include information on the important role that individual vaccination plays in herd immunity, Viewpoint authors say.

The authors noted that hesitancy based on freedom of choice may really reflect a mistrust of the medical community, particularly among some African Americans whose fear stems from historical and contemporary mistreatment and disparities in care. The authors recommended that public health campaigns enlist cultural leaders outside of medicine and public health "to develop and spread culturally relevant messaging and ensure educational content is shared via readily accessible venues and formats."

Create a robust education campaign

Misinformation campaigns are already circulating the idea that a COVID-19 vaccine is "tyrannical" and conspiracy theorists are telling people that a forced vaccine will inject a microchip to track individuals and cull the global population.

Robust public educational campaigns need to use traditional and social media platforms to monitor and combat that information immediately "before dangerous myths take root in the public psyche," the essay explains.

Engage front-line health professionals

Those on the front lines of health care, especially physicians whom patients trust, will play a key role in encouraging patients to receive a COVID-19 vaccine. Studies show that physicians who talk about their personal immunization decisions play a big role in encouraging hesitant families to receive vaccinations.

Nurses and allied health professionals' attitudes also will be important and Viewpoint authors say "ensuring that all individuals who interface with patients in the clinical setting are confident about the safety and effectiveness of a future COVID-19 vaccine is critical for presenting a unified message of strong vaccination support from the medical community."

COVID-19 EVIDENCE WATCH: WHAT DOCTORS MUST KNOW ABOUT MEDICAL PREPRINTS

By: Tanya Albert Henry, AMA Contributing News Writer

Well before the COVID-19 pandemic, many physicians were concerned about problems that could arise from papers being published on preprint servers before undergoing a thorough peer-review process.

In 2017, Howard Bauchner, MD, JAMA editor-in-chief and senior vice president of AMA scientific publications and multimedia applications, penned an editorial saying that "sacrificing adequate and thoughtful peer review and editorial assessment is a mistake for research in medicine."

Fast forward to today's pandemic. The hunt for a COVID-19 treatment is moving at warp speed and there's a voracious demand for the latest information on discoveries. Mirroring that atmosphere, papers posted to - and traffic on - preprint servers has skyrocketed.

MedRxiv, a preprint server for health sciences, and bioRxiv, a preprint server for biology, combined saw the number of papers jump to more than 1,400 in April, about double the 717 on the preprint servers in March. The usage on the sites grew too, with medRxiv experiencing nearly 6.9 million abstract views in March, up from slightly more than 65,000 views in December.

The intense interest has sometimes resulted in papers going up on a preprint server one day to then have major daily newspapers reporting on the studies the next day.

For example, some seized on a study that raised the possibility of hydroxychloroquine taken with azithromycin as possible COVID-19 treatments. However, those who read the full study were concerned that it didn't fully support its conclusions, the AMA's Chief Health & Science Officer Mira Irons, MD, said.

Emerging research in the form of clinical trials are not supportive of their use in COVID-19 and have raised safety concerns, including cardiac risks, but the paper had already taken on a life of its own. The AMA joined the American Pharmacists Association and American Society of Health-System Pharmacists in issuing a joint statement on inappropriate ordering, prescribing or dispensing of medications to treat COVID-19.

"It's an example of the potential harm that can result because of not critically evaluating the paper and whether the design of the study and the results fully support the conclusions," Dr. Irons said.

Physicians - and anyone else - looking at studies on preprint servers should bring along a healthy dose of skepticism, she explained.

"You have to really understand what you are looking at," Dr. Irons said. "It requires more skepticism than you might have when reading a study that has undergone the peer-review process and more personal responsibility to really read the entire paper - and not just the abstract - and act as a reviewer might to determine if the methods and the results support the conclusion - because you can't assume that anyone else has done that important process for you."

Peer review's value

Many busy physicians don't have time to sit and read an entire journal article. Instead, they often just look at the abstract, Dr. Irons said.

When it's gone through the peer-review process, that three-paragraph abstract has been vetted to back up what's in the paper. Multiple independent, unbiased reviewers who are experts in the field examine the paper's methods and conclusions to determine whether everything supports the authors' case. And there is a give-and-take process for reviewers to ask authors questions. Finally, medical journal editors ensure everything is communicated correctly, has context and doesn't lead readers to conclude something the authors didn't intend.

"I look at peer review as an independent analysis. It's like a quality control," Dr. Irons said.

That verification and review may be underway for a preprint article, Dr. Irons

said, but physicians looking at preprints need to understand the peer-review process hasn't yet been performed.

"You have to read the entire paper from beginning to end and do your own due diligence before just accepting the authors' conclusion," she said.

Dr. Irons said physicians should go to medical journals' websites during the pandemic, as many studies are published online before they come across physicians' desks in print editions.

Journals expedite peer review

In the 2017 JAMA editorial, "The Rush to Publication An Editorial and Scientific Mistake," Dr. Bauchner notes that the JAMA Network™ in the past five years had halved the time it took from submission to publication and that journal editors expedite peer review when articles make critically important contributions to clinical care.

That turnaround has been shortened even further at JAMA during the pandemic, while still maintaining accuracy and reliability. Dr. Bauchner said COVID-19 manuscripts for the AMA's JAMA Network of journals are now turned around in two to four days instead of the typical week to 10 days. Physicians can also find resources at the JAMA Network COVID-19 resource center.

SARS-COV-2 SEROLOGY TESTS: 3 BIG LIMITATIONS DOCTORS MUST UNDERSTAND

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

Results from the SARS-CoV-2 serology tests that have flooded the market should not be used to make decisions by individuals, such as whether to end physical distancing.

That warning is part of new guidance from the AMA on serological testing for SARS-CoV-2 antibodies that outlines three major limitations to the tests that physicians must understand to properly order them and interpret their results.

"Given that we do not yet have scientific evidence showing if, when and for how long individuals might become immune to COVID-19, physicians and the general public should not use antibody testing to consider anyone immune to the disease - doing so may lead individuals to falsely assume they can stop physical distancing and further the spread of illness.," said AMA President Patrice A. Harris, MD, MA.

"Although many are using these tests to determine whether an individual had COVID-19, we encourage physicians to only use antibody tests authorized by the Food and Drug Administration [FDA] and only for the purposes of population-level studies, evaluating recovered individuals for convalescent plasma donations, or along with other clinical information as part of a well-defined testing plan for groups or individuals."

Serology tests also have inherent limitations, including a significant risk of false-positive results when disease prevalence is low, Dr. Harris said. Read more about the FDA's new SARS-CoV-2 antibody test rules.

Why it's important: Much discussion has focused on the potential use of SARS-CoV-2 serology testing to develop so-called immunity passports or to ease the physical distancing countermeasures that are limiting the deadly spread of COVID-19.

The FDA is now requiring all commercial test manufacturers to apply for an emergency use authorization to offer their tests on the market. The FDA has also provided recommended performance criteria for these tests. Physicians should pay close attention to the regulatory status of any test offered. FDA maintains a listing of all serological tests authorized for use for COVID-19.

Doctors and patients must understand that these serological tests for SARS-CoV-2 antibodies are especially difficult to interpret because so much remains unknown about immune status for this novel coronavirus. Here are three major limitations physicians should know about.

False-positive results. Serological testing for disease with a low prevalence in the population presents inherent challenges with interpretation of positive results. Even high-performing tests - that is, those are highly specific and sensitive

- will return false-positive results when disease prevalence is low, as is now the case with COVID-19.

Cross-reactivity. While this may not be true of all serology tests for SARS-CoV-2, cross-reactivity has been a noted concern among some offered tests. This happens when a test for antibodies for SARS-CoV-2 identifies not only antibodies for this virus, but also for other coronaviruses, such as those causing the common cold.

Immune status. According to the World Health Organization, there is no current evidence showing immunity to COVID-19 after infection. While individuals typically develop some type of immune response after exposure to most viruses, it is not yet clear when an immune response develops after COVID-19 infection, how strong this immune response may be, and how long the immune response may last.

Use of serology tests should currently be limited to population-level seroprevalance study, evaluation of recovered individuals for convalescent plasma donations, or as part of a well-defined testing plan in concert with other clinical information by physicians well-versed in interpretation of serology test results.

COVID-19 CONTACT TRACING, ISOLATION ARE KEY: HOW TO DO THEM ETHICALLY

By: Timothy M. Smith, AMA Senior News Writer

The use of tracing and then isolating or quarantining individuals who have had contact with people infected with SARS-CoV-2 could prove to be among the most effective tools in reducing transmission of the virus in the U.S. But patients and physicians alike want to make sure individual rights, most notably privacy and confidentiality, don't get trampled in the process.

The AMA has created an ethics resource page, "Ethical practice in isolation, quarantine and contact tracing," that offers ethics guidance on this vital public health measure. Citing numerous opinions from the AMA Code of Medical Ethics, the page provides a comprehensive guide to help physicians understand their public health responsibility to work with institutions or agencies responding to the threat of COVID-19 in their communities.

Getting the word out

"Especially with something as severe and highly transmissible as SARS-CoV-2, we need to identify an infected individual's contacts both for the health of the community and for the health of those contacts themselves," said Elliott Crigger, PhD, director of ethics policy at the AMA. "There's a way of achieving both goals simultaneously. Contacts need to know that they've been exposed, and then they need to take appropriate action to isolate themselves or we need to be able to test them and provide treatment."

Physicians play a crucial role in this process early on. Referring to opinion 8.11, "Health promotion and preventive care," the resource page quotes the Code as saying that "physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies." That includes, the page notes, notifying public health authorities when patterns in patient health may indicate a health risk for others.

Likewise, physicians should educate patients and communities about public health threats, including their potential harm to others and the benefits of quarantine and isolation. Citing opinion 8.4, "Ethical use of quarantine and isolation," the resource page notes that physicians should encourage voluntary adherence and "support mandatory measures when patients fail to adhere voluntarily."

Respecting privacy, confidentiality

Still, contact tracing "carries implications both for the confidentiality of the patient diagnosed with an infectious disease and the privacy of individuals the patient identifies as contacts," the resource page notes.

Citing opinion 3.2.1, "Confidentiality," it advises that physicians involved in contact tracing "should, to the greatest extent possible, protect the confidentiality of the patient by restricting disclosure to the minimum necessary information, for example, by not identifying the patient when advising third parties of their exposure."

Patients must be informed of this, though, so physicians should notify them that information about their contacts will be shared with public health authorities for use in contact tracing to limit spread of the disease and potentially treat those who have been exposed, the resource page says. The same Code opinion also notes that there are some circumstances in which physicians may disclose information to appropriate authorities without a patient's explicit consent.

Continued on next page

THINKING TWICE ABOUT THE RUSH TO GIVE CPR TO COVID-19 PATIENTS

By: Timothy M. Smith, AMA Senior News Writer

Hospitals across the U.S. still face the possibility of their intensive care units being maxed out due to the COVID-19 pandemic, leading some front-line physicians to wonder whether it might ever be appropriate to unilaterally withhold cardiopulmonary resuscitation (CPR) to the sickest patients. In some circumstances, according to medical ethics experts, the answer is yes.

The AMA has created an ethics resource page, "DNR orders in a public health crisis," that offers expert advice on when and why this extraordinary measure may be ethically justifiable. Citing numerous opinions from the AMA Code of Medical Ethics, the page provides a comprehensive guide to the ethical questions in play.

Why it's an issue

Ordinarily, the patient or surrogate is vested with authority to accept or request orders not to resuscitate, the resource page notes, citing opinion 5.4, "Orders Not to Attempt Resuscitation (DNAR)." In addition, the opinion specifies that physicians should provide resuscitation when the patient's wishes are not and cannot immediately be known.

"But there have been conversations during the COVID-19 pandemic about making it a mandate, so it's not a decision between patient and physician," said Elliott Crigger, PhD, director of ethics policy at the AMA. "There's a lot of concern around that, but there's also good reason for withholding CPR, beyond the probable lack of benefit to the patient."

Given the intense activity that ensues during a resuscitation, there is heightened risk to health care workers, Crigger noted.

CPR involves multiple staff, and extubating the patient creates an opportunity for transmission at a very high level," he said. "If the patient had an appreciable chance to recover to discharge, that would make it a much harder call. But evidence indicates that for COVID-19 patients on ventilators, CPR is very unlikely to be successful, while there is very clear risk to health care workers."

Check out the ethics resource page on obligations to protect health care professionals.

Weighing benefit and risk

That low chance of recovery alone is enough to justify withholding CPR to intubated patients, the resource page says. Opinion 5.5, "Medically Ineffective Interventions," directs physicians to recommend and provide only those interventions that are medically appropriate.

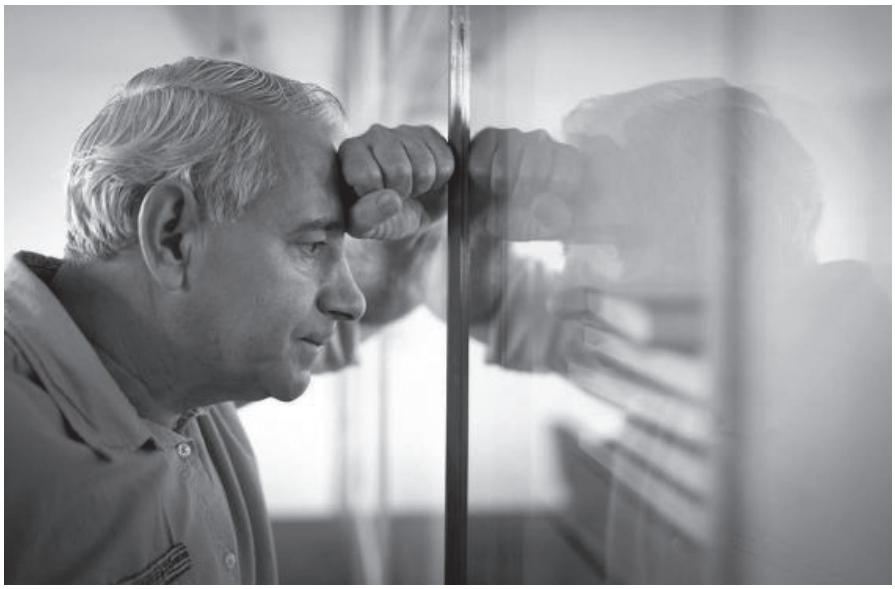
It also says that physicians must not offer or provide care that "cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care."

So if no clinical benefit is expected from CPR, the page says, "opinion 5.5 thus allows physicians to withhold it without explicit consent from the patient or surrogate even under usual conditions."

But opinion 8.3, "Physicians' Responsibilities in Disaster Response and Preparedness," goes further. While it establishes physicians' responsibility to provide care even at risk to themselves, it also directs them to balance the risks of caring for individual patients with the need to be available to provide care in the future.

"In a public health crisis, the goal is to maximize benefit (and minimize harm) for the greatest number of patients," the page says. "Carrying out CPR for a patient who is being treated for a severe, highly contagious disease may pose an unacceptably high level of risk for health care professionals involved in the resuscitation effort, especially when there is little likelihood the patient will survive."

The AMA ethics resource pages - which now address more than a dozen issues at the heart of the COVID-19 pandemic, including crisis standards of care, fair access to limited critical care resources and prioritizing the rest of health care in a public health crisis - have been developed based on inquiries from physicians and policymakers.



COVID-19 MAKES TELEMEDICINE MAINSTREAM. WILL IT STAY THAT WAY?

By: Tanya Albert Henry, Contributing AMA News Writer

Telehealth had been gaining momentum in recent years, but the COVID-19 pandemic is propelling physician practices to quickly figure out how they can best use the technology to provide patients with care while practicing physical distancing.

And the change is expected to have a lasting impact on medicine.

AMA experts shared details about resources they have created to help physician practices quickly launch telehealth - including the continuously updated AMA quick guide to telemedicine in practice - during an American Medical Informatics Association (AMIA) webinar on telehealth during COVID-19. They also discussed how the Trump administration has been a willing and engaged partner with the AMA in greatly expanding Medicare coverage for services provided through telehealth and improving its payment policies so that physicians can offer the services to more patients and get paid for practicing medicine this way.

The Drug Enforcement Administration and the Substance Abuse and Mental Health Services Administration have also implemented new policies to help patients who need controlled substances for pain relief or treatment for opioid-use disorder. During the COVID-19 public health emergency, controlled substance prescriptions may be based on telehealth visits, including audio-only telephone visits, and physicians who prescribe buprenorphine for opioid-use disorder can initiate or continue this treatment with telehealth or phone visits.

While no one can predict exactly how much telemedicine will be used once the pandemic is over, experts at the AMA and physicians on the front lines agree that this experience will result in it being more widely used than it was before the pandemic.

"There are going to be changes in the practice of medicine going forward based on all this use of telehealth. We are quite certain of that," said Sandy Marks, the AMA's senior assistant director for federal affairs. "We are definitely going to be pushing for some of these new policy flexibilities to remain in place."

Connecting doctors with resources

In addition to paying for audio-only telephone calls, the Centers for Medicare & Medicaid Services (CMS), among other things, implemented temporary policy changes that pay for telehealth services at the same rate as in-person visits, expanded what services are covered, and stopped enforcing rules that require a physician to have a previous relationship with a patient.

Physicians can find up-to-date information on payment and policies at the AMA's resource on CMS payment policies and regulatory flexibilities during the COVID-19 emergency.

These changes have "been integral in helping to allow for the acceleration and use of telehealth across the industry," AMA Digital Health Strategy Manager Stacy L. Lloyd, MPH, explained. In response, the AMA has developed telehealth resources for physicians.

Among these is the Telehealth Implementation Playbook, which walks physicians through a 12-step process to implement real-time audio and visual visits between a clinician and a patient. Lloyd said it will be a powerful resource for practices as they continue to implement telehealth beyond the pandemic.

Telehealth in action

Three physicians joined the webinar to discuss the innovative ways their institutions are using telehealth during the pandemic.

Indiana University Health quickly coordinated ambulatory visits across the state using an existing telehealth platform. There were more than 32,000 virtual clinic visits statewide as of April 20 and centralized clinical algorithms in a virtual COVID-19 hub screened thousands of patients across Indiana.

At New York's Mount Sinai's virtual urgent care practice, telehealth went from a system that some physicians used to one that onboarded many new health care professionals from a number of specialties to provide COVID-19 guidance to patients with different severities of the illness.

Boston Children's Hospital began using telehealth to treat patients in the hospital and connect families to their children, promoting physical distancing and preserving hard to get personal protective gear.

Physicians agreed there are issues that will need to be addressed going forward, including equity for patients who don't speak English and for those who don't have access to smartphones or the internet. But, they predicted, telemedicine will play a more prominent role in medicine going forward.

"The genie is out of the bottle in terms of the things that are just a home run [when it comes to telemedicine] ... things that can be done truly very well virtually," said Emily C. Webber, MD, a pediatric hospitalist and chief medical information officer at Riley Hospital for Children in Indianapolis.

Reopening Your Practice: Avoid Risks when Treating Stressed Patients during COVID-19

WHILE MOST RESOURCES ARE DIRECTED AT SCREENING FOR COVID-19 AND TREATING AFFECTED PATIENTS, THERE IS ANOTHER IMPORTANT ASPECT OF THE PANDEMIC: THE IMPACT ON YOUR PATIENTS' MENTAL HEALTH.[1]

Anxiety is being exacerbated by patients' mistrust of the healthcare system and fear that they or their loved ones will contract the virus. A recent survey indicated that 67 percent of people have increased levels of stress since the start of the COVID-19 outbreak[2]

What are some warning signs or cues that show a patient is in emotional distress? Watch for the following signs when seeing a patient onsite or via telehealth:

- Changes in appetite, sleep, and/or behavior.
- Nonverbal cues during an interview.
- Decreased or no energy.
- Changes in cognition.
- Feelings of hopelessness/helplessness, being overwhelmed, irritability, fear/worry.
- Withdrawal from friends/family and activities.
- Increased conflict within relationships.
- Lack of follow-through with seeing therapist and/or psychiatrist.
- New somatic complaints.
- Excessive smoking, drinking, or using drugs.

If these warning signs are missed and an adverse event – such as suicide – occurs, the healthcare provider may face the risk of a medical malpractice claim.

While the vast majority of your patients who are anxious and stressed about the COVID-19 virus are not suicidal, it is important to keep in mind the possibility of suicide as you complete your assessment. A helpful resource is the Suicide Prevention Toolkit for Primary Care Practices (www.sprc.org/settings/primary-care/toolkit) from the Suicide Prevention Resource Center and the Western Interstate Commission for Higher Education Mental Health Program.

The following key elements of the Stress First Aid peer support model[3] have been linked to better functioning during times of ongoing stress and should be used in discussion with patients showing signs of anxiety:

- COVER: Restore and support a sense of safety.
- CALM: Calm and orient distressed persons by asking if they have experienced any changes.
- CONNECT: Connect in a helpful and respectful manner.
- COMPETENCE: Remind them of skills that have worked in the past for them.
- CONFIDENCE: Foster a sense of hope, limit self-doubt and guilt, and help patients concentrate on strengths

During these discussions, explain to patients the importance of self-care during times of stress and the importance of staying connected to their support system. Provide positive encouragement and reinforcement.

References

[1] Diamond R. Watch for the signs: Screen all patients for suicidal thoughts. The Doctors Company. Published November 2016. Accessed May 19, 2020. https://www.thedoctors.com/articles/watch-for-the-signs-screen-all-patients-for-suicidal-thoughts/

[2] Qualtrics. The other COVID-19 crisis: Mental health. Published April 2020. Accessed May 19, 2020. https://www.qualtrics.com/blog/confronting-mental-health/

[3] National Center for PTSD. For Leaders: Supporting Your Staff During the Coronavirus (COVID-19) Pandemic. Published April 9, 2020. Accessed May 18, 2020. https://www.ptsd.va.gov/covid/COVID_leaders_support_staff.asp

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!*

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