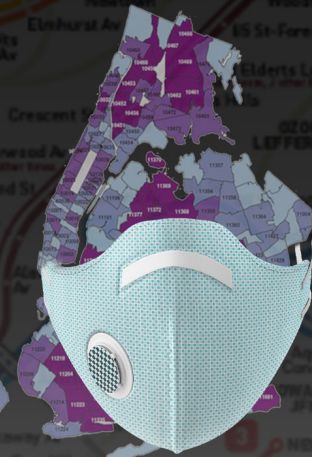


# RECONSIDERING HEALTH CARE IN THE ERA OF PANDEMICS



Second Annual  
Best Practices Conference

August 11, 2020

Provided by: Icahn School of Medicine at Mount Sinai and Healthfirst



Icahn School  
of Medicine at  
Mount  
Sinai



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Health Insurance for New Yorkers

## PROGRAM OVERVIEW

The role of primary care in promoting health and well-being is especially important for the following individuals: those with complex medical challenges; those with social and economic vulnerabilities; and those who are impacted by COVID-19 due to infection, social distancing, economic displacement, or disruption in access to routine and emergent care.

The goal of this activity is to increase attendees' knowledge of emerging strategies for addressing health needs and reducing racial health disparities among New Yorkers in the era of COVID-19. The event will address strategies to optimize meaningful and measurable health outcomes for individuals in populations impacted by COVID-19. Participants will consider the tools and resources that can address opportunities, challenges, and impact on managing the health of New Yorkers impacted by COVID-19, including policymaking; social, geographic, racial, and age-related factors; and structural components of the healthcare delivery system.

## LEARNING OBJECTIVES

By the end of the event, participants will be able to:

- Define the health profile and accumulation of risk in populations most vulnerable to infection with COVID-19.
- Recognize challenges to achieving optimal health outcomes for patients and communities suffering from COVID-19 infection, especially as relates to racial disparities and equity.
- Identify current and new models of care, social factors, and policies on health outcomes for the post-COVID-19 healthcare delivery system.
- Implement pragmatic skills to integrate at least one evidence-based approach in their practice or organization to reduce health disparities by race and ethnicity.

## TARGET AUDIENCE

Medical directors, physicians, physician assistants, nurse practitioners, nurses, and practice leaders who serve high-risk populations.

## ACCREDITATION STATEMENT

The Icahn School of Medicine at Mount Sinai is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

## CREDIT DESIGNATION

The Icahn School of Medicine at Mount Sinai designates this live activity for a maximum of 5.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

## SPECIAL NEEDS

Icahn School of Medicine at Mount Sinai fully complies with the legal requirements of the Americans with Disabilities Act and the rules and regulations thereof. Participants with special needs are requested to contact the Page and William Black Post-Graduate School of Medicine at 1-212-731-7950.



# AGENDA

Tuesday, August 11, 2020

## Opening Remarks

8:00AM—8:05AM

**Susan J. Beane, MD**

*Executive Medical Director, Healthfirst*

**Jonathan Arend, MD**

*Associate Professor, Medicine, General Internal Medicine, Mount Sinai Health System*

## Special Lecture: Ethnic Concordance between the Physician and the Patient and What it Means for the Future of Healthcare Disparities after COVID-19

8:05AM—8:35AM

**Errol Pierre, MPA**

*Senior Vice President, State Programs, Healthfirst*

8:35AM—8:50AM

Question and Answer Session

## Keynote Presentation: Creating a New Population Health Reality

8:50AM—9:20AM

**Robert Fields, MD, MHA**

*Senior Vice President, CMO Population Health, Mount Sinai Health System*

9:20AM—9:35AM

Question and Answer Session

## Panel 1

9:35AM—10:15AM

Creating Care Plans for Post-Acute Care in the COVID-19 Pandemic

**Pauline Jones, M.Ed, FNP-BC, CRRN**

*Assistant Vice President, Nursing Administration, Burke Rehabilitation Hospital*

# AGENDA

## Emotional Health in the Time of COVID

**Anitha Iyer, PhD**

*Director, Behavioral Health Population Management, Mount Sinai Health Partners*

*Associate Professor of Psychiatry, Icahn School of Medicine at Mount Sinai*

10:15AM—10:45AM

Question and Answer Session

10:45AM—10:55AM

Break: 10 Minutes

## Panel 2

## Telemedicine in the Era of COVID-19

**Jay M. Portnoy, MD**

*Professor of Pediatrics, U. Missouri-Kansas City School of Medicine and Medical Director of Telemedicine, Children's Mercy Hospital*

10:55AM—11:35AM

## Technology and Aging Adults: Opportunities in a Pandemic

**Sara J. Czaja, PhD**

*Professor of Gerontology, Director, Center on Aging and Behavioral Research, Weill Cornell Medicine*

11:35AM—12:05PM

Question and Answer Session

## Panel 3

## National Organizing of Volunteers and Resources

**Marc L. Napp, MD, MS, FACS**

*Senior Vice President, Medical Affairs & Deputy Chief Medical Officer, Mount Sinai Health System*

12:05PM—12:45PM

# AGENDA

Health Care Workforce Well-Being in the Wake of COVID-19: The Mount Sinai Experience

**Jonathan Ripp, MD, MPH**

*Chief Wellness Officer, Mount Sinai Health System, Senior Associate Dean for Well-Being+Resilience, Icahn School of Medicine at Mount Sinai, Co-Chair, Collaborative for Healing and Renewal in Medicine (CHARM)*

12:45PM—1:15PM

Question and Answer Session

Closing

1:15PM—1:30PM



**Susan J. Beane, MD**  
**Executive Medical Director**  
**Healthfirst**

Susan J. Beane, MD, joined Healthfirst in 2009, bringing with her extensive professional experience in managed care. As Vice President and Executive Medical Director at Healthfirst, Dr. Beane focuses on care management and clinical provider partnerships, especially programs designed to improve the delivery of vital, evidence-based healthcare to our members. Dr. Beane, a dedicated primary care physician and board-certified internist, is a strong proponent of collaborating with and engaging providers to improve health outcomes.

Prior to joining Healthfirst, Dr. Beane served as Chief Medical Officer for Affinity Health Plan for five years, during which time she helped Affinity's plan become a top performer in quality and member satisfaction. Before that, she worked at AmeriChoice and HIP USA, as Medical Director. Dr. Beane is a graduate of Princeton University and Columbia University College of Physicians and Surgeons.

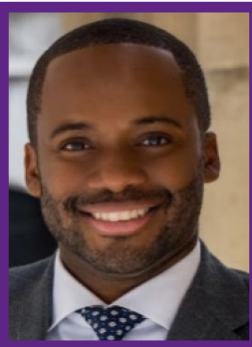




**Jonathan Arend, MD**  
**Associate Professor, Medicine, General Internal Medicine**  
**Mount Sinai Health System**

Dr. Arend has been a member of the Division of General Internal Medicine at the Icahn School of Medicine at Mount Sinai since 2011, with the rank of Associate Professor of Medicine. Dr. Arend practices primary care at Internal Medicine Associates, where he also teaches medical students and residents and serves as Associate Medical Director for Clinical Operations and Clinical Quality.

Dr. Arend also serves as Medical Director of Population Health for hospital-based practices across Mount Sinai Health System. Dr. Arend received his undergraduate degree from the University of Puget Sound and his MD from Louisiana State University School of Medicine in New Orleans. He completed his residency training in the Primary Care/Social Internal Medicine Residency Program at Albert Einstein College of Medicine/Montefiore Medical Center. His interests include healthcare delivery innovation, quality improvement, and population health management.



**Errol Pierre, MPA**  
**Senior Vice President, State Programs**  
**Healthfirst**

Errol Pierre is the Senior Vice President of State Programs at Healthfirst, Inc., the largest not-for-profit health plan in New York State, serving 1.5 million members. In this role, he is accountable for growth, profit/loss, and sales and retention for the Medicaid and Long-Term Care product portfolios. Additionally, he provides strategic and operational direction for the company, which includes the execution of the annual growth strategy and community partnerships.

Prior to Healthfirst, Errol spent more than 12 years at Empire BlueCross BlueShield, the largest for-profit health plan in New York State. Empire is a Medicaid and Medicare health plan in New York City and Long Island serving close to five million members. Errol started his career in healthcare at Empire as an intern, in 2003. Throughout his tenure, he held various leadership roles in Sales and Strategy until leaving the company as the Vice President and Chief Operating Officer in 2019.

A Bronx, New York resident, Errol graduated from Fordham University with a bachelor's degree in Business Administration with a concentration in Finance. He later obtained a master's degree in Health Policy and Financial Management from New York University. He is a doctoral student at Baruch College focused on Healthcare and Business.

Errol is an adjunct professor for Molloy College, teaching Health Economics in their Healthcare MBA program. In his spare time, Errol volunteers for various non-profit organizations. He serves as a board member of the West Side YMCA. He is a board member and Co-Chair of the One Hundred Black Men Health & Wellness Committee. Lastly, he mentors both high school students and Fordham undergraduates in the Bronx. In 2014, Errol was recognized as one of The Network Journal's 40 under 40 for his volunteer efforts. In 2015, he was recognized as the Volunteer of the Year for the YMCA of Greater NY and awarded the Percy Allen, II Healthcare Award from the NY Chapter of the National Association of Health Services Executives (NAHSE).



**Robert Fields, MD, MHA**  
**Senior Vice President, CMO Population Health**  
**Mount Sinai Health System**

Dr. Robert Fields is a family medicine physician and the Senior Vice President and Chief Medical Officer for Population Health at Mount Sinai Hospital in New York City. As CMO, Dr. Fields leads a network of more than 4,000 physicians managing the clinical and financial outcomes of 450,000 lives across multiple risk contracts and all lines of business.

Dr. Fields began his career as an independent physician providing primary care for all ages, including a large number of underserved Latino patients in Western North Carolina. He was part of the system leadership team that designed the first ACO in that region and was asked to serve as its first clinical leader. Under his guidance, the network achieved more than \$11 million in savings in the Medicare Shared Savings Program and additional savings in various Medicare Advantage contracts. Dr. Fields came to Mount Sinai in March of 2018 as the SVP and Chief Medical Officer for Population Health and has overseen the redesign of the clinical model, including care management, provider engagement, quality programs, practice transformation, social determinants, and other aspects of the system's population health strategy.

Dr. Fields serves as the Chair-elect of the National Association of ACOs (NAACOS) and serves on the Board of America's Physician Groups (APG). He is also the Co-Chair of the Measure Applications Partnership group for the National Quality Foundation and a member of the Core Quality Measures Collaborative for NQF. He earned his medical degree from the University of Florida College of Medicine, and completed a Family Medicine Residency at the Mountain Area Health Education Center in Asheville, NC, where he was Chief Resident. Dr. Fields earned his Master of Health Administration from the University of North Carolina at Chapel Hill.



**Pauline Jones, M.Ed, FNP-BC, CRRN**  
**Assistant Vice President, Nursing Administration**  
**Burke Rehabilitation Hospital**

Pauline Jones, M.Ed, FNP-BC, CRRN, is the Assistant Vice President (AVP) of Nursing at Burke Rehabilitation Hospital. Jones has worked at Burke since 2001, and prior to her current role she was the Nurse Educator, Nursing Supervisor, and most recently Director of Patient Screening. In her role as the AVP Nursing, Jones works closely with the Chief Nursing Officer (CNO) and Executive Leadership team to implement the mission, vision, policies, goals, and objectives of the organization and the Nursing Division in order to provide patient-centered care. The Assistant Vice President of Nursing is a liaison among nursing leadership, other disciplines, and administration, promoting the philosophy and goals of the organization, the development of team relationships, and congruent rehabilitation practices. Jones assists in directing nursing services to ensure that a high level of 24-hour nursing care is given to all patients. She carries out the operations and quality management aspects of nursing administration in order to meet regulatory requirements and the Burke nursing expectations for care.

Jones is also an avid educator, in the New York region and nationally. As a Certified Family Nurse Practitioner, her mission is to bridge the gap between theory and practice. Prior to joining Burke, Jones held multiple leadership and staff roles in an acute care hospital. During the COVID-19 pandemic, Jones was instrumental in creating surge beds, implementing the guidelines from the CDC and New York State Department of Health, ensuring staff well-being and safety, and continuing to provide quality care to Burke patients.





**Anitha Iyer, PhD**  
**Director, Behavioral Health Population Management**  
**Mount Sinai Health Partners**  
**Associate Professor of Psychiatry**  
**Icahn School of Medicine at Mount Sinai**

Dr. Anitha Iyer is the Director of Behavioral Health Population Management at Mount Sinai Health System, and Associate Professor of Psychiatry at the Icahn School of Medicine at Mount Sinai. Prior to joining Mount Sinai, Dr. Iyer was the Chief Clinical Officer and Vice President of Crisis and Behavioral Health Technologies for Vibrant Emotional Health, a New York City-based not-for-profit organization. Here she helped implement and run large-scale, state-of-the-art behavioral health programs, including, most notably, NYC Well.

She is a recognized leader in the innovative delivery of crisis services, a frequent speaker at behavioral health and suicide prevention conferences across the nation, and has served as a subject matter expert for media engagement on matters pertaining to mental health and suicide prevention. She also serves on the Board of Directors of Sakhi for South Asian Women, a New York City-based organization that supports South Asian survivors of interpersonal and gender-based violence. She is multilingual and fluent in English, Tamil, and Hindi/Urdu. Dr. Iyer, a licensed Clinical Psychologist, earned her PhD in Clinical Psychology from Columbia University Teachers College, and her BA in Biology from Barnard College.



**Jay M. Portnoy, MD**  
**Professor of Pediatrics, U. Missouri-Kansas City School of**  
**Medicine and Medical Director of Telemedicine**  
**Children's Mercy Hospital**

Dr. Jay Portnoy is an allergist in the section of Allergy, Asthma & Immunology and Medical Director of Telemedicine at Children's Mercy Hospital in Kansas City, Missouri, and Professor of Pediatrics at the University of Missouri-Kansas City School of Medicine. He received his medical degree at the University of Missouri-Columbia School of Medicine, and he did his pediatric residency at the Children's Mercy Hospital in Kansas City and his Allergy fellowship at the University of Michigan in Ann Arbor. Following that, he returned to Children's Mercy Hospital.

Dr. Portnoy has published numerous articles in peer-reviewed journals involving asthma disease management, environmental control, mold allergy. More recently he has been involved in evidence-based medicine and telemedicine and was co-chair of the Joint Taskforce on Practice Parameters. He was co-director of the Kansas University Medical School's allergy program from 1985 to 1997, and he founded the UMKC School of Medicine's allergy program, directing it from 1997 to 2006. Dr. Portnoy served as President of the American College of Allergy, Asthma & Immunology in 2008, and he has served on numerous committees, both of the American College and the American Academy of Allergy, Asthma & Immunology as well as on the Allergy/Immunology Residency Review Committee of the ACGME and the American Board of Allergy and Immunology.

He lives in Overland Park, KS, with his wife and two cats. Fortunately, nobody in the family has cat allergy.



**Sara J. Czaja, PhD**  
**Professor of Gerontology, Director, Center on Aging  
and Behavioral Research**  
**Weill Cornell Medicine**

Sara J. Czaja, Ph.D., is a Professor of Gerontology and the Director of the Center on Aging and Behavioral Research in the Division of Geriatrics and Palliative Medicine at Weill Cornell Medicine. She is also an Emeritus Professor of Psychiatry and Behavioral Sciences at the University of Miami Miller School of Medicine (UMMSM). Prior to joining the faculty at Weill Cornell, she was the Director of the Center on Aging at the UMMSM.

Dr. Czaja is also the Director of the NIH multisite Center for Research and Education on Aging and Technology Enhancement (CREATE) and Co-Director of the Center for Enhancing Neurocognitive Health, Abilities, Networks, & Community Engagement (ENHANCE), funded by NIDILRR. Her research interests include: aging and cognition, caregiving, aging and technology, aging and work, training, and functional assessment. She has received continuous funding from the National Institutes of Health and other funding agencies to support her research, and has published extensively on these topics. She is a fellow of the American Psychological Association (APA), the Human Factors and Ergonomics Society, and the Gerontological Society of America. She served as the Past President of Division 20 (Adult Development and Aging) of APA, as a member of the National Research Council/National Academy of Sciences Board on Human Systems Integration, as a member of the Institute of Medicine (IOM) Committee on the Public Health Dimensions of Cognitive Aging, and as a member of the IOM Committee on Family Caring for Older Adults.

Dr. Czaja is the recipient of the 2015 M. Powell Lawton Distinguished Contribution Award for Applied Gerontology from the APA; the 2013 Social Impact Award for the Association of Computing Machinery (ACM), and the Franklin V. Taylor Award from Division 21 of APA. She is also the recipient of the Jack A. Kraft Award for Innovation from HFES, the APA Interdisciplinary Team, and the 2019 Richard Kalish Innovative Book Publication Award (GSA) with CREATE. She recently was selected as the recipient of the 2020 M. Powell Lawton Award from The Gerontological Society of America (GSA).



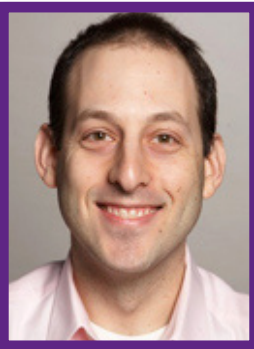
**Marc L. Napp, MD, MS, FACS**  
**Senior Vice President, Medical Affairs & Deputy Chief**  
**Medical Officer**  
**Mount Sinai Health System**

Dr. Napp serves as Senior Vice President for Medical Affairs and Deputy Chief Medical Officer of the Mount Sinai Health System.

Overseeing medical staff operations for the eight-hospital system, he is involved in managing healthcare quality, regulatory compliance, medico-legal affairs, physician leadership development, and emergency management.

After graduating cum laude from Princeton University with a Bachelor of Science in Chemical Engineering, Dr. Napp received his MD from the Albert Einstein College of Medicine and was elected to Alpha Omega Alpha. He completed a general surgery residency at Mount Sinai Medical Center. After completing his training, he entered private practice and went on to obtain a Master of Science in Administrative Medicine from the University of Wisconsin. He subsequently transitioned to a career as a physician executive, holding leadership positions at Hudson Valley Hospital, Lenox Hill Hospital, Manhattan Eye, Ear and Throat Hospital, and Northwell Health, before coming to Mount Sinai.





**Jonathan Ripp, MD, MPH**  
Chief Wellness Officer, Mount Sinai Health System, Senior Associate Dean for Well-Being+Resilience, Icahn School of Medicine at Mount Sinai, Co-Chair, Collaborative for Healing and Renewal in Medicine (CHARM)  
**Mount Sinai Health System**

Jonathan Ripp, MD, MPH, is Professor of Medicine, Medical Education and Geriatrics and Palliative Medicine, Senior Associate Dean for Well-Being and Resilience, and Chief Wellness Officer at the Icahn School of Medicine at Mount Sinai (ISMMS). He received both his undergraduate and medical degrees from Yale University and completed internship and residency in Internal Medicine (IM) at the Mount Sinai Hospital in New York City.

In the role of chief wellness officer, Dr. Ripp oversees efforts to assess and provide direction for system- and individual-level interventions designed to improve well-being for all students, residents, fellows, and faculty in the Mount Sinai Health System. He is the former Associate Dean of GME for Trainee Well-Being within the ISMMS Office of Graduate Medical Education, in which capacity he helped to spread well-being initiatives across the training programs of the Mount Sinai Health System. Dr. Ripp also co-founded and is the former Director of the ISMMS Department of Medicine's Advancing Idealism in Medicine (AIM) Initiative. In the Department of Medicine, Dr. Ripp serves as core faculty for the IM Residency Training Program and faculty in the Mount Sinai Visiting Doctors home-based primary care program. In addition, Dr. Ripp is the Co-founder and Co-Director of CHARM, the Collaborative for Healing and Renewal in Medicine, an international group of medical educators, academic medical center leaders, experts in burnout research and interventions, and learners all working to promote learner and trainee wellness.

Recognized for his leadership in this area, Dr. Ripp has been invited to participate in the Accreditation Council on Graduate Medical Education (ACGME) Symposia on Physician Well-Being, join the American College of Physician's Promoting Physician Wellness Task Force, and participate in the National Academy of Medicine's Action Collaborative on Clinician Well-being and Resilience. Dr. Ripp's primary research interest is in physician burnout and well-being, for which he has received grant support and has published and lectured widely. His multicenter studies have served to better elucidate the causes and consequences of physician burnout and have explored interventions designed to promote trainee well-being.

# Ethnic Concordance between the Physician and the Patient and What it Means for the Future of Healthcare Disparities after COVID-19

Errol L Pierre, MPA  
Doctoral Candidate (Expected 2021)  
Zicklin School of Business  
Baruch College

August 2020



*Preliminary work - not to be copied, distributed or cited.*

## Purpose and Objectives

### PURPOSE

*To understand the relationship between ethnic concordance, physician/patient communication and adherence.*

### OBJECTIVES

- Showcase the impact of healthcare disparities in the United States.
- Highlight several factors that drive these disparities.
- Review the current literature in this space.
- Provide an overview of an experiment seeking to understand this problem more closely.

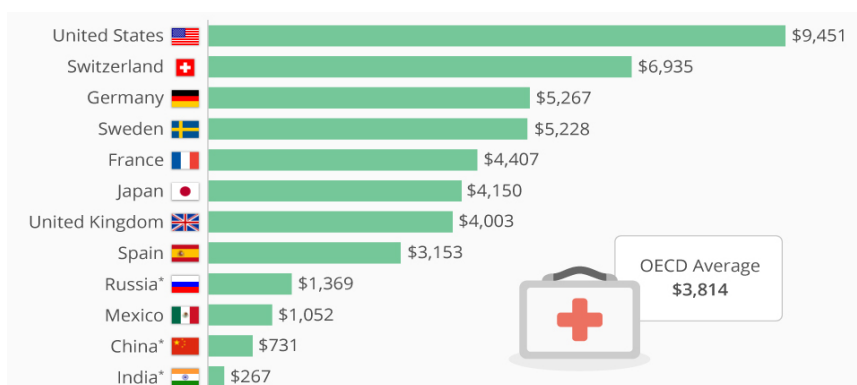
### FINANCIAL DISCLOSURE

*None*



## The American Healthcare Crisis

United States spends close to twice as much as 10 similarly high income countries despite covering a lower proportion of citizens with lower quality levels and poorer health outcomes. Nonetheless, there is a similar number of physicians and patient utilization rates. (Papanicolas et. al, 2018)

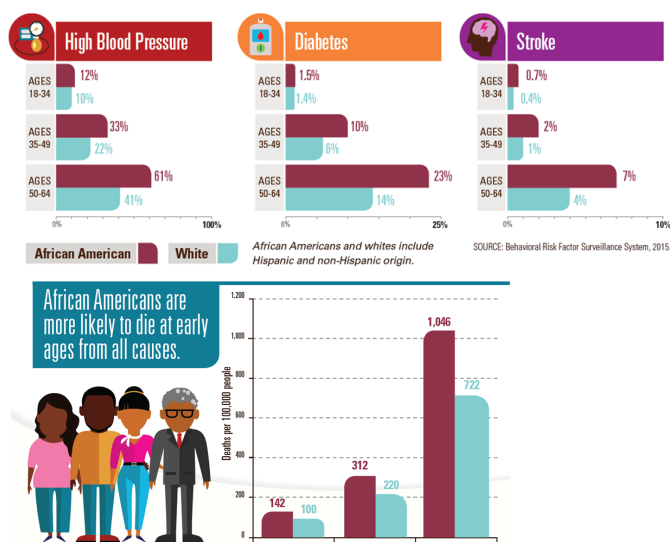


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## Disparities in Healthcare Outcomes

- \$230 Billion – Savings from eliminating health disparities for minorities from 2003-2006.
- \$1 Trillion – Savings in indirect costs associated with illness and premature death from 2003-2006

(LaVeist, Gaskin & Richard, 2011)



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## COVID-19 Realities to Racial/Ethnic Disparities

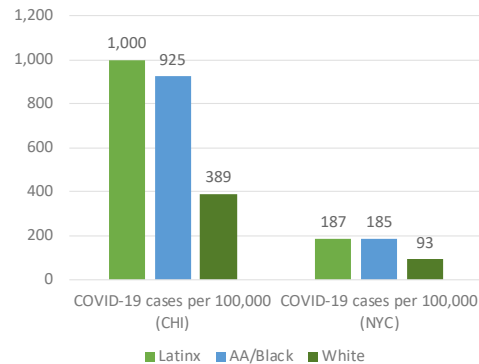
### COVID-19 and Racial/Ethnic Disparities

Hooper, M., Napoles, A., Perez-Stable, E., (2020)  
JAMA. 2020;323(24):2466-2467.

The most severe presentation of COVID-19 is acute respiratory distress syndrome, which has led to severe complications and death.

- Select underlying medical comorbidities have been identified as biological vulnerabilities for more severe COVID-19 outcomes.
- Racial/ethnic minority populations have a disproportionate burden of these underlying comorbidities
- Geographic locations that reported data by race/ethnicity indicate that African American & Latinx individuals bear a disproportionate burden of COVID-19 related outcomes.
- The underlying causes of health disparities are complex and include social and structural determinants of health, racism and discrimination, economic and educational disadvantages, health care access and quality, individual behavior, and biology.

### COVID-19 Cases per 100,000 NYC & CHI



## Patient/Physician Ethnic Concordance Studies

The New York Times

### *The Secret to Keeping Black Men Healthy? Maybe Black Doctors*

In an intriguing study, black patients were far more likely to agree to certain health tests if they discussed them with a black male doctor.



Dr. ChaRandle Jordan was one of the doctors who participated in the study. "It's something they don't teach you in medical school - taking that extra step because you appreciate there have been barriers in the past," he said.

Brian L. Frank for The New York Times

August 20, 2018

### Does Diversity Matter for Health? Experimental Evidence from Oakland – Alsan, Garrick, Graziani; National Bureau of Economic Research.

- Based on a study in Oakland
- Paired African-American men with both white and African-American physicians.
- Each patient was offered a range of preventive care services in increasing degrees of invasiveness.
- **Findings:** African-American patients with African-American physicians were more likely to agree to the preventive care services offered vs. those offered by white physicians.
- **Additional findings:** African-American physicians had higher levels of "effort" for their African-American patients.





# Ethnic Concordance = No Significant Differences

Association between patient-provider racial and ethnic concordance and patient-centered communication in outpatient mental health clinics.

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Mujica, Christin Alvarez, Kiara Tendulkar, Shalini Cruz-Gonzalez, Mario Alegria, Margarita

## Citation

Mujica, C., Alvarez, K., Tendulkar, S., Cruz-Gonzalez, M., & Alegria, M. (2020). Association between patient-provider racial and ethnic concordance and patient-centered communication in outpatient mental health clinics. *Journal of Psychotherapy Integration*. Advance online publication. <https://doi.org/10.1037/int0000195>

## Abstract

Patient-centered communication (PCC) has been identified in the literature as central to providing quality care to patients. Some evidence suggests that racial/ethnic patient-provider concordance may be associated with increased PCC because of perceived similarity between the patient-provider match. This study examines whether there are differences in emotion focused PCC between racial/ethnic concordant ( $n = 55$ ) and discordant ( $n = 36$ ) dyads in a sample of behavioral health providers ( $n = 34$ ) and their patients ( $n = 91$ ) recruited from community mental health care settings as part of a larger study. PCC was measured using three items from a novel third-party coding system on whether providers "identified feelings," "accepted feelings," and "encouraged emotional expression" of the patient. Three separate mixed linear regression analyses were conducted to assess relationships between racially/ethnically concordant or discordant dyads and each of the communication items: (a)  $\beta = .20$ ,  $p = .12$ ; (b)  $\beta = 0.12$ ,  $p = .39$ ; and (c)  $\beta = -0.05$ ,  $p = .75$ . No significant differences were found between groups in the three items, suggesting that racial/ethnic concordance may not be linked to PCC measures related to emotion. It is possible that racially/ethnically discordant providers may compensate for cultural barriers to communication through additional emotion-focused communication strategies, or that other aspects of patient-provider similarity are more salient to PCC. Continuing to identify the characteristics and circumstances that lead to improved PCC may be a way to bridge the gaps in the quality of behavioral health care received by underserved communities, particularly communities of color. (PsycINFO Database Record (c) 2020 APA, all rights reserved)

**H1: Patient-centered communications leads to high quality care to patients.**

**Research Question:** Does Racial/Ethnic Concordance help?

## Sample Size

Racial/Ethnic Concordant ( $n = 55$ )  
Racial/Ethnic Discordant ( $n = 36$ )

**Results:** Three separate mixed linear regression analyses were conducted.

(a)  $\beta = .20$ ,  $p = .12$

(b)  $\beta = 0.12$ ,  $p = .39$

(c)  $\beta = -0.05$ ,  $p = .75$

**Findings:** *No Statistical Significance*

7 7/29/20

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# What About Racial Bias?

THE WALL STREET JOURNAL  
Home World U.S. Politics Economy Business Tech Markets Opinion Life & Arts Real Estate WSJ Magazine  
US | NEW YORK  
**New York Regulator Probes UnitedHealth Algorithm for Racial Bias**  
Financial Services Department is investigating whether algorithm violates state antidiscrimination law



A UnitedHealthcare spokesman said the algorithm was only one part of a larger tool that offers to help analyze patients' health needs. PHOT: MIKE BRADLEY/BLOOMBERG NEWS

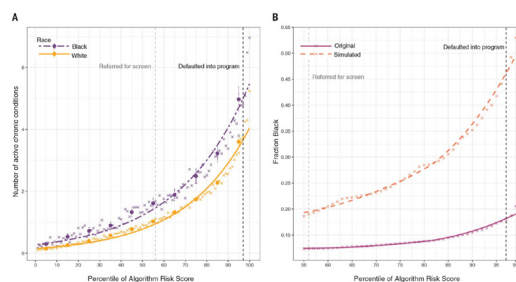
By Melanie Evans and Anna White Matthews  
Oct 26, 2019 7:00 am ET

## RESEARCH ARTICLE

### ECONOMICS

## Dissecting racial bias in an algorithm used to manage the health of populations

Ziad Obermeyer<sup>1,2\*</sup>, Brian Powers<sup>3</sup>, Christine Vogeli<sup>4</sup>, Seshil Mullainathan<sup>1,2\*</sup>



**Fig. 1. Number of chronic illnesses versus algorithm-predicted risk, by race.** (A) Mean number of chronic conditions by race, plotted against algorithm risk score. (B) Fraction of black patients at or above a given risk score for the original algorithm ("original") and for a simulated scenario that removes algorithmic bias ("simulated"): at each threshold of risk, defined at a given percentile on the x axis, healthier Whites above the threshold are

replaced with less healthy Blacks below the threshold, until the marginal patient is equally healthy). The x symbols show risk percentiles by race; circles show risk deciles with 95% confidence intervals clustered by patient. The dashed vertical lines show the auto-identification threshold (the black line, which denotes the 95th percentile) and the screening threshold (the gray line, which denotes the 95th percentile).



# Ethnic Concordance + Bias = Significant Differences

## PEDIATRICS<sup>®</sup>

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Section on Emergency Medicine Program

### A Systematic Review of Implicit Racial Bias in Healthcare

Ivy Manna

Pediatrics January 2018, 141 (1) MeetingAbstract 137. DOI: [https://doi.org/10.1542/peds.141.1\\_MeetingAbstract.137](https://doi.org/10.1542/peds.141.1_MeetingAbstract.137)

**Background:** Disparities exist in the care and outcomes of racial/ethnic minorities in the US, including children in the pediatric emergency department (ED). Research suggests that provider implicit bias plays a role in healthcare disparities. The implicit association test (IAT) enables measurement of implicit attitudes via tests of automatic associations between concepts. Hundreds of studies have examined implicit attitudes in various settings, but relatively few have been conducted in healthcare. **Objectives:** To synthesize the current knowledge on the role of implicit bias in healthcare disparities. **Methods:** We searched 4 databases for key words related to healthcare providers, implicit bias, and race/ethnicity. After screening to exclude ineligible articles, two independent reviewers performed data abstraction of full texts for relevant articles. **Results:** Our search yielded 6249 articles and we identified 33 qualifying studies. Thirty studies found evidence of pro-White/anti-Black or Latino bias among a variety of healthcare providers. Types of providers included physicians (e.g., pediatric, surgery, emergency medicine, internal medicine), physician assistants, counselors, nurses, psychologists, occupational therapists, and healthcare students. Three studies focused on implicit bias in the pediatric setting. Two found that implicit racial bias was associated with racial disparities in pain management. One found that cognitive stressors in the pediatric ED were associated with higher levels of bias among residents post-ED shift compared to pre-shift. One additional study in the general ED setting found that increased bias was associated with disparities in chest pain management. Thirteen studies examined the association between implicit bias and healthcare outcomes using clinical vignettes or simulated patients, yielding mixed results. Seven found no association between implicit bias and patient care. However, six studies found that higher implicit bias was associated with disparities in treatment recommendations, expectations of therapeutic bonds, pain management, and empathy. Six studies examined the impact of implicit provider bias on real-world patient care. Only 1 found no association between IAT scores and healthcare disparities. However, 5 found that providers with stronger implicit bias demonstrated poorer patient provider communication and worse psychosocial outcomes for their patients. Only 4 studies tested interventions aimed at reducing bias. Two examined the effect of multicultural training, but only 1 found a post-intervention reduction in implicit bias. Two studies

### Meta-Analysis

**H1: Implicit Bias plays a role in healthcare disparities.**

**Method:** Searched 4 databases for keywords: healthcare provider, implicit bias, race/ethnicity.

6,249 articles w/ 33 qualifying studies

**Results:** Thirty studies found evidence of pro-White/anti-Black or Latino bias among a variety of healthcare providers.

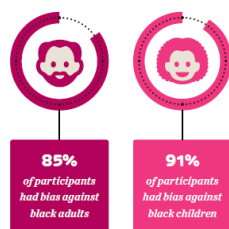
- Six studies showed implicit bias in patient care.
- Five studies showed strong implicit bias leads to less communication and very poor outcomes

# Ethnic Concordance + Bias = Significant Differences

## Children's Hospital of Philadelphia administered both Child/Adult Race Implicit Association Tests (IATs) to 91 resident physicians in a large pediatric ED in western Pennsylvania.

Johnson, T., Winger, D., Hickey, R., Switzer, G., Miller, E., Nguyen, M., Saladino, R., Hausmann, L., (2016).

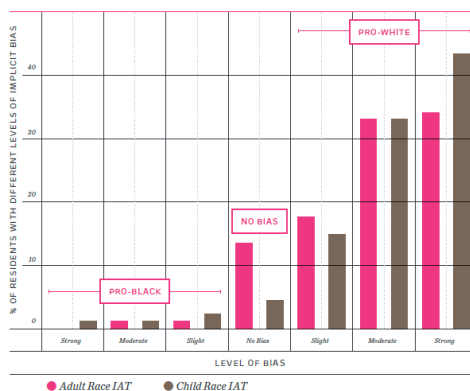
**Most resident physicians in our study had pro-white/anti-black bias on both the Adult Race IAT and Child Race IAT, which reflects other research on implicit bias on the general population.**



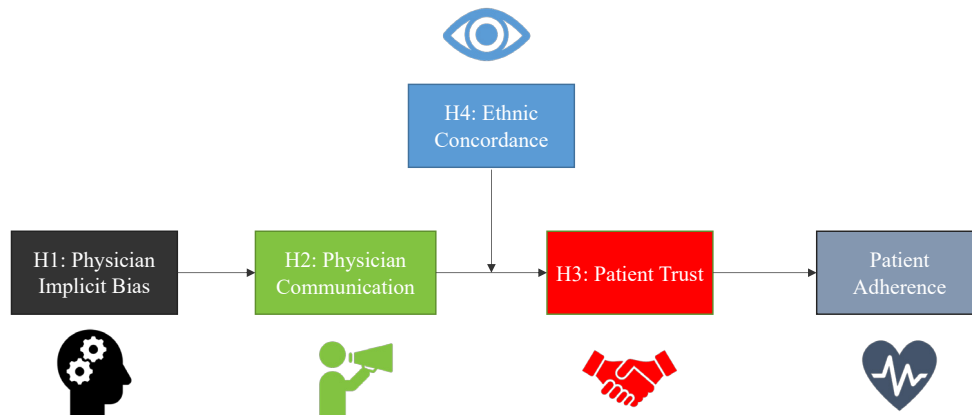
**Neither Adult Race or Child Race IAT scores varied by resident personal characteristics.** Pediatric residents in our study had similar implicit biases as resident physicians from other specialties (i.e. emergency medicine residents, family medicine residents).

**Physicians in our study had similar scores on the Adult and Child Race IAT, indicating comparable levels of bias against black adults and black children.**

### PERCENTAGE OF RESIDENTS WITH DIFFERENT LEVELS OF IMPLICIT BIAS TOWARDS ADULTS AND CHILDREN



## The Model



## Physician Implicit Bias

**H1: Implicit bias, consciously or unconsciously, negatively impacts the ability for physicians to effectively communicate with their patients.**

- Variations in patient satisfaction scores regarding clinical interactions of black patients were determined by the race of the physician and that physician's perception of the race of their patient. (Penner, Dovidio, Manning, Albrecht, van Ryn, 2018)
- At a Veteran Affairs Medical hospital, minority patients "did less to prompt doctors for information", which led to physicians providing less information and visits being 40% shorter when paired with a white physician. (Gordon et al., 2006).
- Low income black patients seeing white physicians were less likely to adhere to their instructions. Additionally, higher levels of physician implicit bias led to lower patient adherence rates. (Hagiwara, 2013)



## Physician Communication

**H2: Effective physician communication including both verbal and nonverbal messaging to patients will lead to an increase in patient trust.**

- Effective physician-patient communication is linked empirically to outcomes of care including patient satisfaction, health status, recall of information, and adherence (Engel, 1992).
- This includes verbal and nonverbal communication measured by accessing (1) effective questioning, (2) transmission of information, (3) expression of empathy and concern, and (4) participation and participatory decision making (Zolnieriek, 2009).
- Patient motivations and complexity of treatment that could involve lifestyle changes can be influenced by physician communication (Martin, 2005).
- Its important for physicians to understand the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (US DHHS, 2000).



## Patient Trust

**H3: Higher rates of trust between physicians and patients will lead to either improved patient adherence rates or improved rates on the patient’s intent to adhere.**

- Patient trust is the degree to which patients feel comfortable with their physician (Campbell, 2005).
- Patients must believe that their physician is someone who can understand their unique experience of being a patient, and someone who can provide them with reliable and honest advice (Branch, 2000).
- Research shows that physicians who promote trust in the therapeutic relationship, who have effective communication and “bedside manner”, and who express compassion for their patients have adherence rates that are 3 times higher (O’Malley et al, 2002).







## Ethnic Concordance

**H4: Ethnic concordance between patients and physicians serves as a moderator to patient trust and will positively influence the relationship.**

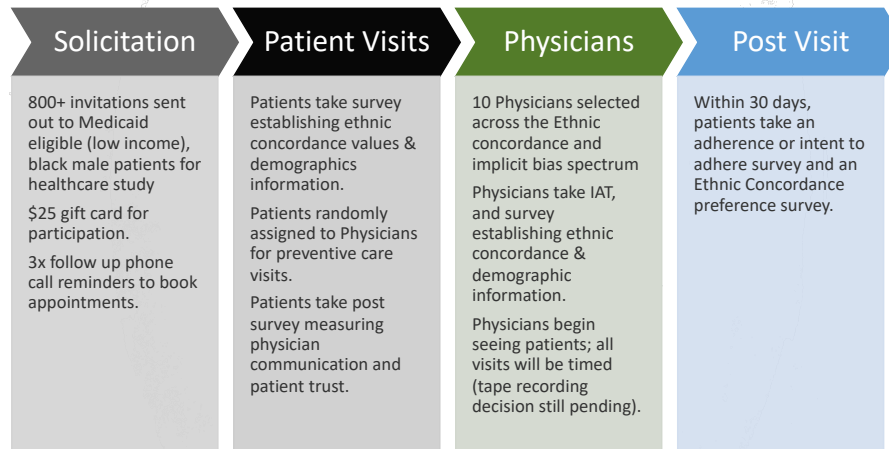
- Ethnic Concordance is defined as the degree of patient and physician similarity or agreement across a given dimension. Differences in gender, race, socioeconomic status, education, expectations, beliefs, and perceptions can impact health care quality. (Thornton 2011).
- Respondents of each racial and ethnic group reported the highest level of satisfaction if they were race concordant. Moreover, all respondents reported greater satisfaction with physicians from their own race. (LaVeist & Nuru-Jeter, 2002).
- Patient perception of similarities with their physician had strong correlation to patient satisfaction and adherence. However, perceived racial similarities were not related to health outcomes (Street, 2008).



Quasi-experiment to examine whether ethnic concordance and implicit bias impact patient adherence rates in black male patients.

- Partnering with a Federally Qualified Health Center (FQHC) in Brooklyn to administer the experiment.
- Eligible patients will be 21 to 64 African American men eligible for Medicaid requiring at least one preventive care service based on HEDIS and QARR national standards.
- Patients will be outreached three times and offered a \$25 gift card for participation.
- All appointments booked will be randomly assigned to a set of physicians. Pairings will be based on two categories:
  - Ethnic Concordance
  - Implicit Bias
- Patients will be offered multiple preventive care services in increasing degrees of complexity & invasiveness.

## The Experiment: Operationalization



## The Experiment: Measures

- **Implicit Bias:** Implicit Association Test (Nosek, Smyth, Hansen, Devos, Lindner, Ranganath, Smith, 2007).
- **Patient Communication:** Medical Communication Competence Scale (Cegala, Coleman, Turner, 1998).
- **Patient Trust:** Trust-in-Physician scale (Anderson & Dedrick, 1990).
- **Ethnic Concordance:** Personal and Ethnic Perceived Similarities Measures (Street, O'Malley, Cooper, Haidet, 2008).
- **Patient Adherence:** Intent to Adhere Questionnaire\*



## The Experiment: Expected Results

“Patient adherence will be the highest where ethnic concordance between patient and physicians are the highest and implicit bias with the physician is the lowest; thus more preventive care services will be rendered regardless of the level of invasiveness. This is due to higher levels of patient trust and effective physician communication.”

- Patient Adherence<sub>i</sub> =  $\beta_0 + \beta_1$  Patient Trust<sub>i</sub> +  $\epsilon$
- Patient Trust<sub>i</sub> =  $\beta_0 + \beta_1$  Physician Communication +  $\beta_2$  Physician Communication \* Ethnic Concordance +  $\epsilon$
- Physician Communication =  $\beta_0 + \beta_1$  Physician Implicit Bias<sub>i</sub> +  $\epsilon$

## The Experiment: Validity Threats

- **Internal Validity**
  - Nonresponse bias: Only using patients that decide to participate in the experiment
  - Assumes all physicians are created equal. Experiment fails to measure variances in the ability for the physician to perform in their role.
  - Does not measure the concept of “physician effort”
  - Conclusion validity concerns that our findings are explained by different reasons than the ones we have observed.
- **External Validity**
  - It is impossible to know if our results are generalizable across other communities of color. Our findings in Brooklyn, NY may differ than other regions in the country.
  - Content validity concerns around how accurate our scales for Ethnic concordance and Implicit bias are to measuring the construct of trust.



## Expected Contributions

- Extend life expectancy for African American males by increasing their exposure to both ethnically concordant physicians and other physicians with low/no implicit bias.
- Improve deliberate physician recruitment campaigns in areas with dense minority populations to better meet the needs of the patient populations.
- Lower the cost of healthcare in America improving efficiency and quality.
- Build on Dr. Theodis Thompson's **Social Accessibility Hypothesis**, that contends that physicians find it very difficult to effectively communicate with their patients, especially when there are cultural differences and on that premise. Thus, the psychosocial accessibility problem of blacks obtaining healthcare would be greatly alleviated through the existence of an appropriate number of black physicians to meet the black demand for healthcare services (Thompson, 1974)



## Contact Information

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# Creating A New Population Health Reality

Rob Fields MD MHA

*SVP CMO Population Health  
Mount Sinai Health System*

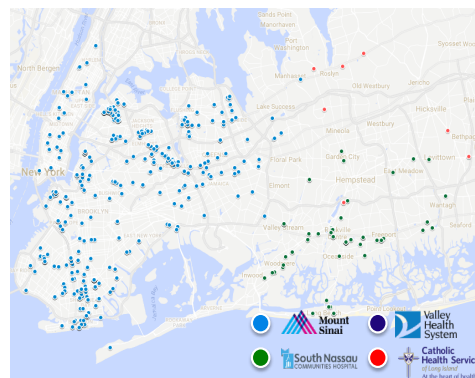


## Mount Sinai Health System: Positioned for Value

**With breadth and depth of assets, Mount Sinai is well positioned as one of the highest-value providers in New York City**

### Health System Assets

- ▶ Icahn School of Medicine at Mount Sinai
- ▶ Flagship academic hospital + 7 community hospitals
- ▶ >300 community care locations throughout NYC Metro
- ▶ >6,600 physicians on medical staff (~3,500 employed)
- ▶ Clinical affiliations that further our geographic reach



## Mount Sinai Health System: Investing in Value

With a focus on value, Mount Sinai has heavily invested in population health solutions, supported by a new business model engaging directly with purchasers of health care

### New Business Model

Key goals include:

- ▶ To become the purchaser's partner of choice
- ▶ Align financial incentives around outcomes
- ▶ Earn trust with our patients so that Mount Sinai is their provider of choice
- ▶ Manage outcomes, patient experience, and costs



### Strategic Initiatives

- ▶ **New Leadership** – hired new leaders to launch a 400+ FTE team dedicated to population health & value
  - ▶ **Network Development** – launched clinically integrated network of hospitals & >4,000 employed and community based physicians
  - ▶ **Changing Compensation** – shifted physician compensation to an outcomes-based model
  - ▶ **Investment in Enablement** – \$100M in IT & services to enable care teams for managing populations
  - ▶ **Quality Management** – standardizing & improving care processes for chronic illness & specialty care
- Value-based contracts with all commercial health plans
- Full risk-based contracts for Medicare/Medicaid lives

March 17<sup>th</sup> 2020

## Pre- Covid

### Focus on Process Improvement

- Site specific engagement and action plans
- Clinical Redesign

### Advanced Predictive Analytics and Care Management

- SDH augmented risk of 30 day admission
- Focus on transitions and prevention of inpatient admission

### In-Person Relationship-based Physician Engagement

- Division of network into operational units
- In-person meetings and planning

## The Covid Reality

- ▶ Fragility of safety net
- ▶ Food Insecurity
- ▶ Lack of primary care and specialty access
- ▶ Disparities in Access to Technology
- ▶ Worsening Behavioral Health Concerns
- ▶ Vulnerability of Independent Primary Care Practices
- ▶ Lack of Hospital Capacity at the Peak of the Virus in NYC

## Pandemic Plan of Action

### Assessment and Management of COVID Risk and Symptoms

- New analytics to identify high COVID risk patients
- Self-service tool for list distribution for outreach

### Engagement in Telehealth

- Outreach efforts included assessment of chronic condition and COVID needs
- Education/engagement in telehealth (**active** engagement and outreach for visits)

### Focused Themes for Outreach

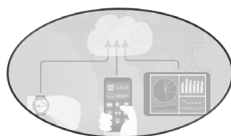
- Chronic condition management, medication access, food insecurity, behavioral health, COVID related symptoms
- Accompanying training guide for practice outreach
- Use of community health workers, students

## Newly Emerging Themes



### Telemedicine

- Shifting policies
- Radical increase in volumes
- Improving patient experience
- Use of peripherals to augment visits



### Remote Monitoring

- Hypertension, CHF, COPD, post-COVID, others
- Power by team-based care structures
- Real-time management
- Focus on patient engagement



### Payer Mix Changes

- Unemployment driving to Medicaid
- Shift in access and ability to manage chronic disease



### Greater Emphasis on Equity

Murder of George Floyd

Differential in COVID Outcomes

Economic Impact of COVID

### Digital Divide

- Access to the new world of telehealth and remote monitoring
- Great opportunity and great risk

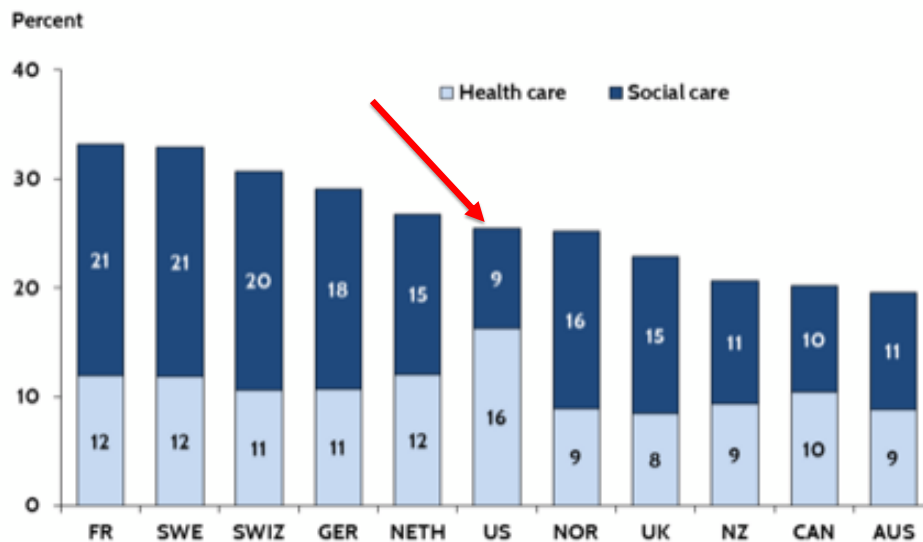
### Differential in Outcomes

- Action to reduce health disparities
- Need to establish trust within vulnerable communities

### Community-based Engagement

- Use of community health workers
- CBO Partners

**Exhibit 8. Health and Social Care Spending as a Percentage of GDP**



Notes: GDP refers to gross domestic product.  
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

### Community Partners = Healthcare Partners

- ▶ Engaging CBOs in healthcare AND healthcare financing
- ▶ Networks of CBOs to augment “typical” healthcare
- ▶ Social determinant drivers AND patient engagement
  - technology
  - chronic condition management
  - linkage to standard health services and telehealth
- ▶ Need for CBOs to participate in healthcare economics
  - improved sustainability
  - “skin in the game”
- ▶ Reimagined processes and technology to facilitate the relationship and the drive towards population health outcomes

### Summary

- ▶ COVID forced a redesign of how we engage our physicians and patients
- ▶ Initial population health strategies focused on COVID related needs and facilitation of telehealth as well as immediate social needs (food, behavioral health)
- ▶ Each successive wave of COVID will drive a change in utilization with an increased focus on telehealth, remote monitoring and all “at home” services
- ▶ Long overdue drive towards equity as an influencer in population health operations
- ▶ To achieve long term population health goals, new strategies and financing for CBO partners required

Thank You

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# Creating Care Plans in the Post Acute Space

Pauline Jones, M. Ed, FNP – BC, CRRN

Assistant Vice President of Nursing

August 11, 2020

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Acknowledgement: Jeffrey Menkes, President and CEO  
and Burke Rehabilitation Senior Leadership

## Presentation Objectives

- Discuss the process by which Burke Rehabilitation Hospital responded to Governor Cuomo's Executive Order due to COVID-19.
- Implementation of the surge ward.
- Describe the process to re-deploy, re-assign, and educate staff to care for the acute rehabilitative patients.
- Describe how Burke Rehabilitation Hospital staff met the complex medical and rehabilitative needs of COVID-19 patients.

## Introduction

The current COVID-19 pandemic has put the global healthcare system into an unprecedented crisis, leaving hospitals overwhelmed and desperate for additional capacity.

Burke Rehabilitation Hospital, a member of the Montefiore Health System (MHS), is a 150-bed freestanding acute inpatient rehabilitation facility (IRF).

Burke, located in White Plains N.Y. (Westchester County), was contiguous to the New York epicenter with regards to this pandemic.

Burke transformed to meet the needs of patients from the MHS and neighboring partners during this medical crisis.

Burke "Created Care Plans for the Post Acute Space."



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- As of July 27, 2020, Globally: 15 million cases Deaths: 618,000  
U.S. 4.2 million cases Deaths: 142,103
- MHS admitted over 2,000 COVID-19 patients.
- The term COVID-19 has been used to describe the illness caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS – CoV 2).
- Many COVID-19 positive patients admitted to the acute care hospital were left with a significant degree of disability possibly due to extended time spent in the ICU, reduced lung function, central neurological syndromes, cardiac/respiratory and peripheral muscular issues rendering them unable to be discharged home.





# The

# PROCESS

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## Phase 1: Prepare

- Established a Command Center
- Limited visitors and access to the hospital (New York State Governor's order).
- Screened Staff.
- Closed Ambulatory Sites.
- Re – Deployed (“Collapse In” ) Ambulatory Therapy Staff for the Inpatient Hospital.
- Increased Oxygen Utilization.
- Created Negative Pressure Rooms.
- Created a 14 bed Surge Unit (Ward).
- Reorganized the Patient Referral and Screening Process.

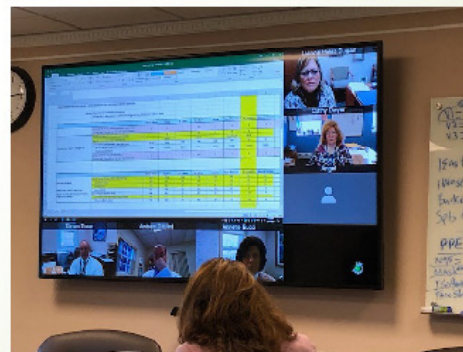
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## Daily Command Center Meetings

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## Stretching Existing Staff

### Before Surge

	1 East	1 West	1 North	2 East	2 West	Total
Nurse Manager Days	1	1	1	1	1	4 *one assigned to 2-10 shift
RN Days	4	5	4	4	5	22
RN Nights	3	4	3	3	4	17
NA Days	5	5	6	6	7	29 *reflects outside appointment needs
NA Eves	4	4	5	5	5	24
NA Nights	3	3	4	4	5	19

### After Surge

	1 East	1 West	1 North	2 East	2 West	1 E Gym	1 W Gym	Total
Nurse Manager Days	1	1	1	1	1			5 *one assigned to 2-10 shift / one nurse educator reassigned
RN Days	3	4	4	3	3	2	3	22
RN Nights	3	3	3	3	3	2	3	20
NA Days	4	4	4	4	5	3	4	28
NA Eves	3	3	3	4	4	3	3	23
NA Night	2	2	3	3	4	2	2	18
PT/OT Redeploy Days	2	2	2	2	2	2	2	14
PT/OT Redeploy Nights	1	1	1	1	1	1	1	7

## Phase 2: Protect

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- Daily calls among CEOs of the Hudson Valley Hospitals in coordination with the Montefiore Health System.
- Medical and Rehabilitation Management of COVID-19 patients.
- Staff Wellness and Morale.
- Distribution and conservation usage of Personal Protective Equipment following evolving CDC strategies.
- Team rounds changed from twice a week to daily to allow greater throughput.
- Increased need for wound care to address special COVID related inflammatory and vascular skin injury (i.e. COVID toes).

White Plains  
Dept. of  
Public Safety  
thanked our  
essential  
workers with  
a parade of  
lights and  
sirens through  
campus



Daily employee temperature screenings

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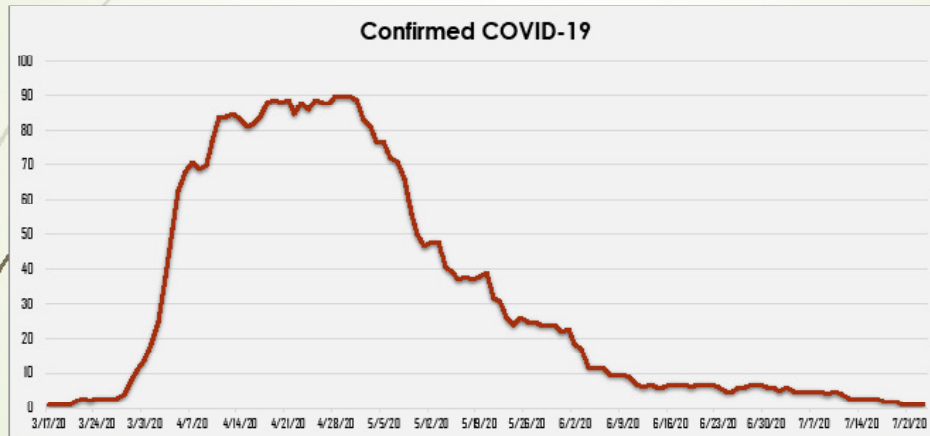
Daily N-95 Mask Distribution



## COVID-19 Cases at Burke

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**Lowest** 3/17, 3/18, 3/19 and 3/20 = 1 Patient

and 7/20, 7/21, 7/22 and 7/23 = 1 Patient

**Highest** on 4/29, 4/29 and 4/30 = 90 Patients

## Phase 3: Protect

### As we look to the Future:

- Focus on the COVID-19 patients that have a rehabilitation (functional) need from their COVID-19 disease.
- Maintain Internal Medicine presence at Burke.
- Assess and make changes to our infrastructure to best meet the need of the patients and staff.

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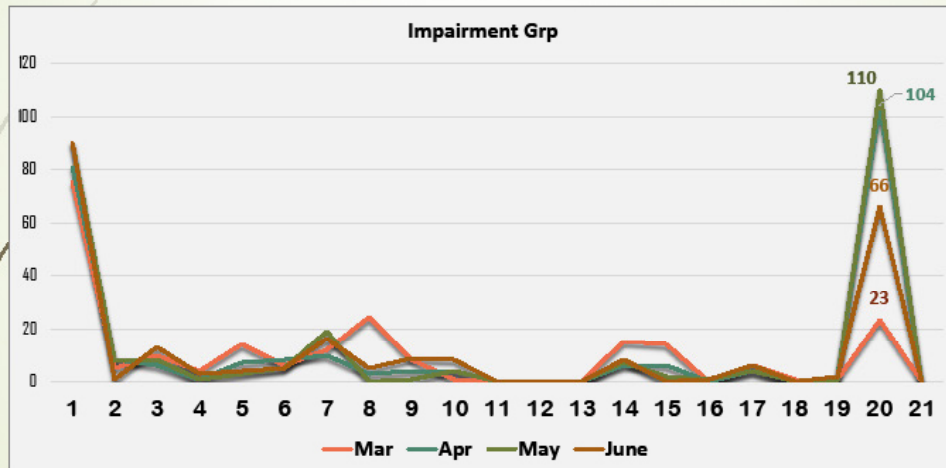
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## COVID-19 Patients and Impairment Groups

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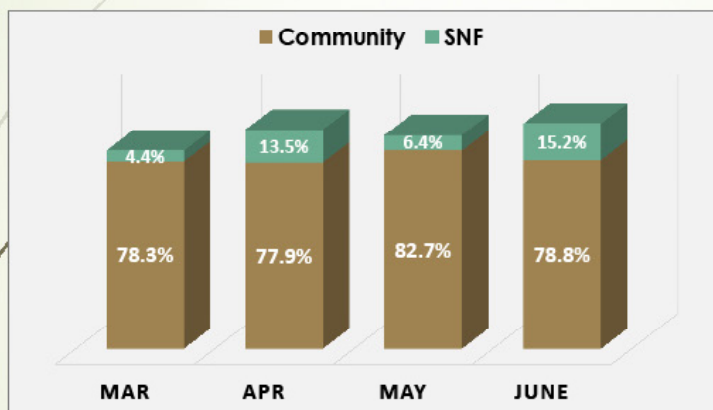
COVID-19 Patients Impairment Grp = Miscellaneous Debility

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## Discharge Disposition

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March = Total of 18 Patients out of 23 discharged to the community

April = Total of 81 Patients out of 104 discharged to the community

May = Total of 91 Patients out of 110 discharged to the community

June = Total of 52 Patients out of 66 discharged to the community



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## Additional Services Offered to Patients During COVID-19 Crisis

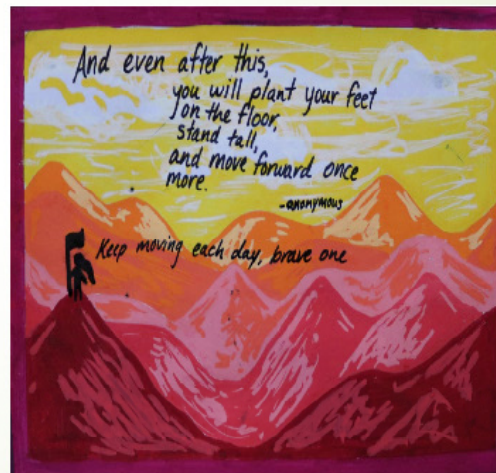
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### Cards of Cheer Program

- ❖ Inspirational cards delivered to hundreds of patients who could not have visitors.
- ❖ Card designs printed as outdoor signs to be seen all over campus to greet and motivate staff.
- ❖ Art display comprised of cards hung on each patient floor to inspire patients and employees alike.

Our thanks to over 75 young artists from throughout the community who responded to the call.



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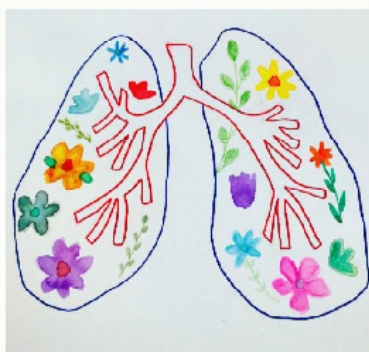
## COVID CHAMPIONS! Celebrating COVID-19 Patient Discharges

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200th COVID patient discharge



250th COVID patient discharge

A wall display was installed on the ground floor of the hospital featuring a tile designed by a college student to honor each COVID positive patient.

Name: \_\_\_\_\_  
Discharge date: \_\_\_\_\_

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## Window Celebrations

Happy Birthday Grandpa!  
Creatively meeting the challenge of restricted  
visitation.

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## Maintaining Family Support

We miss you Dad!

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## BURKE's Connect Program

### Socializing using iPads

More than 20 therapists facilitated social visits for over 50 patients.

And 10 clinicians used iPads to connect with patients, families and other clinicians.



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## Virtual Pet Therapy at BURKE

Meet  
Sammy!



Burke patients can schedule a FaceTime visit and enjoy interacting with Sammy and his owner too. Thanks to our iPads and a partnership with **The Good Dog Foundation**.

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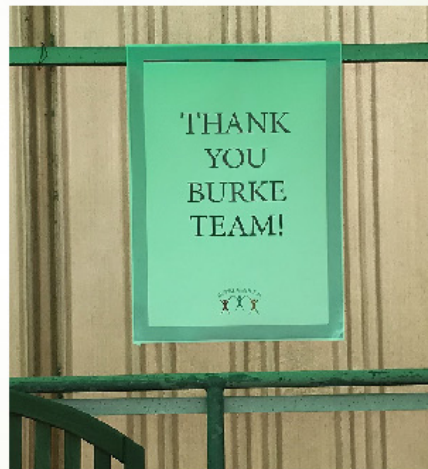
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# Burke Rehabilitation Hospital

COVID-19: Recognition & Support of Staff

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Confidential & Proprietary

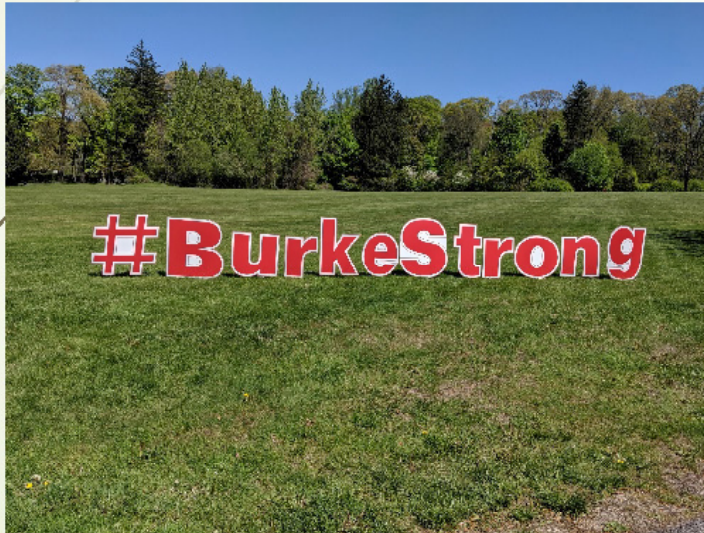
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Thank You





# BURKE

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# Emotional Health in the Time of COVID

Anitha Iyer, PhD

Director, Behavioral Health Population Management, Mount Sinai Health Partners

Associate Professor of Psychiatry, Icahn School of Medicine and Mount Sinai



## Purpose and Objectives

### PURPOSE

*Share emerging trends and contributing factors for the emotional impact of COVID.*

### OBJECTIVES

- Highlight the factors associated with emotional reactions to COVID
- Share emerging national trends of COVID related stress, anxiety and depressive symptoms
- Provide strategies and resources for supporting patients

### FINANCIAL DISCLOSURE

*None*

## Agenda

1. Emotional Reactions to COVID-19
2. Emerging Trends
3. Resources for Patients
4. Q&A

## Emotional Reactions to COVID-19

## Emotional Reactions to COVID

### Stress during any infectious disease outbreak

- Fear and worry about one's own health of the health of loved ones
- Changes in sleeping and/or eating patterns
- Difficulty sleeping or concentrating
- Worsening of chronic health problems
- Worsening of mental health conditions
- Increased use of substances

### Additional stressors due to COVID

- Depression/disrupted social connections due to isolation
- PTSD symptoms/avoidance/anger due to quarantine stress
- Grief due to loss of loved ones
- PTSD symptoms/depression due to prolonged financial stress
- Childcare issues
- Guilt about one's relative advantages compared to others
- Exacerbated stresses from social determinants such as poverty, language barriers
- Discrimination based on age, race, or other factors
- **Provider Stressors**
  - Direct risk to safety/health
  - New treatment methods/ initiatives
  - New billing methods and guidelines
  - Supporting staff
  - Absorbing patient stresses

\*<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html>

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▶ Disrupted routine

▶ Altered responsibilities/division of labor

▶ New/worsened stresses/responsibilities

▶ "Absence makes the heart grow fonder"

- Fears (diffuse/specific)
- "Breaking News is Scary!"
- Stress(es) in the home
- Lack of structure/routine
- Loss of social contact
- Remote learning
- Missed milestones (graduation etc.)

- Fear of being "high risk"
- Fear of losses
- Disrupted social connections
- Difficulty maintaining preventive care

# Emerging Mental Health Trends\*

## Why “Trends\*” ?

- ▶ We are still in the thick of it
  - Ongoing complex trauma
  - Data gathering, analysis, understanding is ongoing
  - Still learning/adapting
- ▶ Potential for change and flux

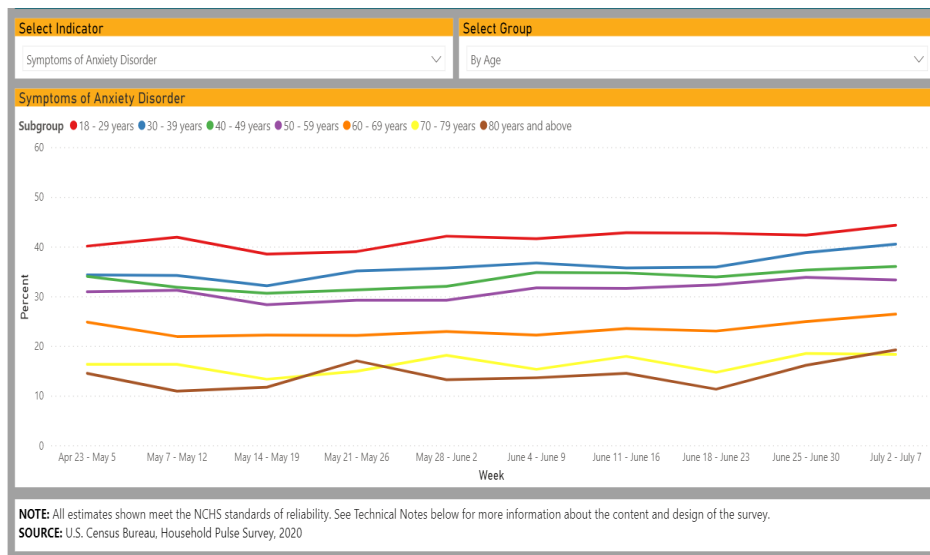
## Centers for Disease Control Survey

- ▶ Centers for Disease Control (CDC)/ National Center for Health Statistics (NCHS) Household Pulse Survey
  - Beginning April 23, 2020
  - 20 minute online survey including PHQ-2 and GAD-2
  - Symptoms over the past 7 days
  - Sample size varied at each time point (Range: 39,447 to 118,897)
  - **30.8%** of respondents reported symptoms of Anxiety between April 23<sup>rd</sup>- May 5<sup>th</sup> vs **34%** between July 2<sup>nd</sup>-July 7<sup>th</sup>
  - **23.5%** of respondents reported symptoms of Depression between April 23<sup>rd</sup>- May 5<sup>th</sup> vs **27.6%** between July 2<sup>nd</sup>-July 7<sup>th</sup>
  - For comparison, the same survey between January through June 2019 yielded:
    - 8.2% reported symptoms of Anxiety
    - 6.6% reported symptoms of Depression

<https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>

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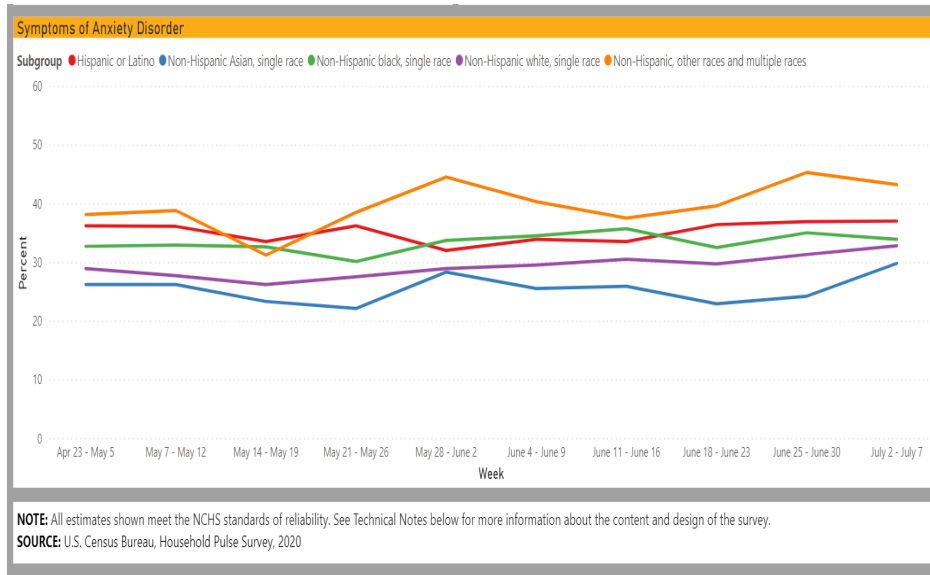
## Anxiety Symptoms Since COVID by Age



10

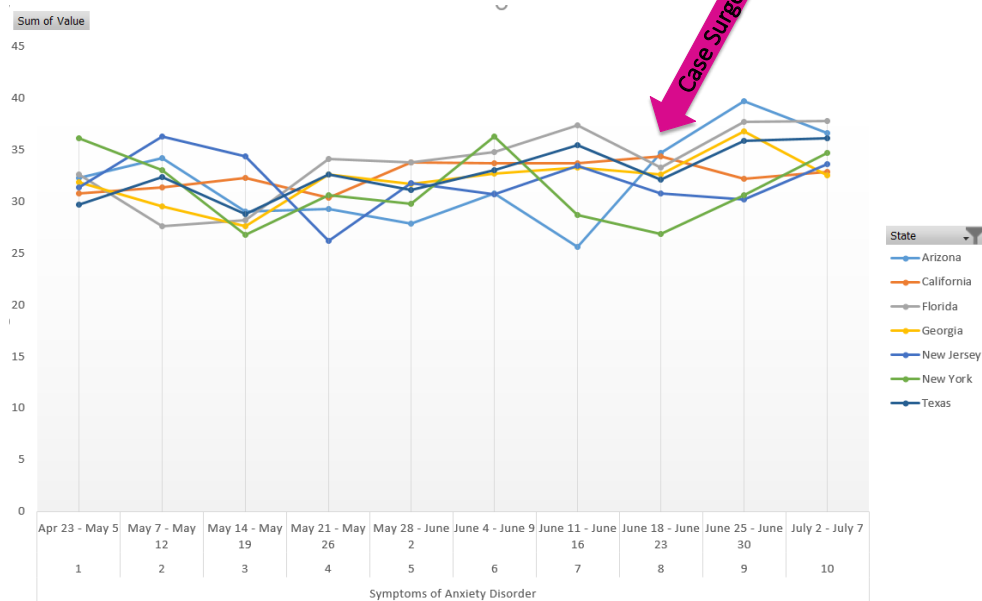


## Anxiety Symptoms Since COVID by Race/Ethnicity



11

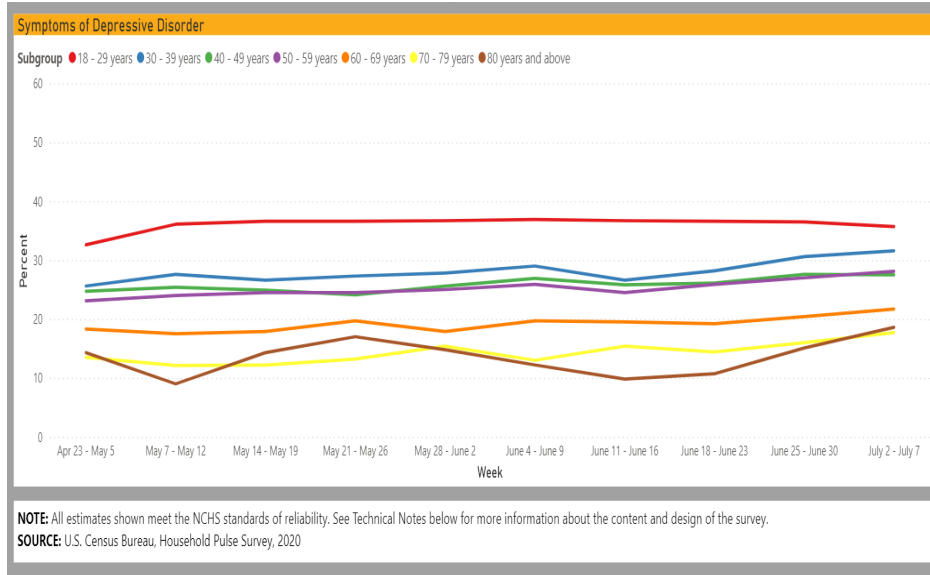
## Anxiety Symptoms Over Time By State



<https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>

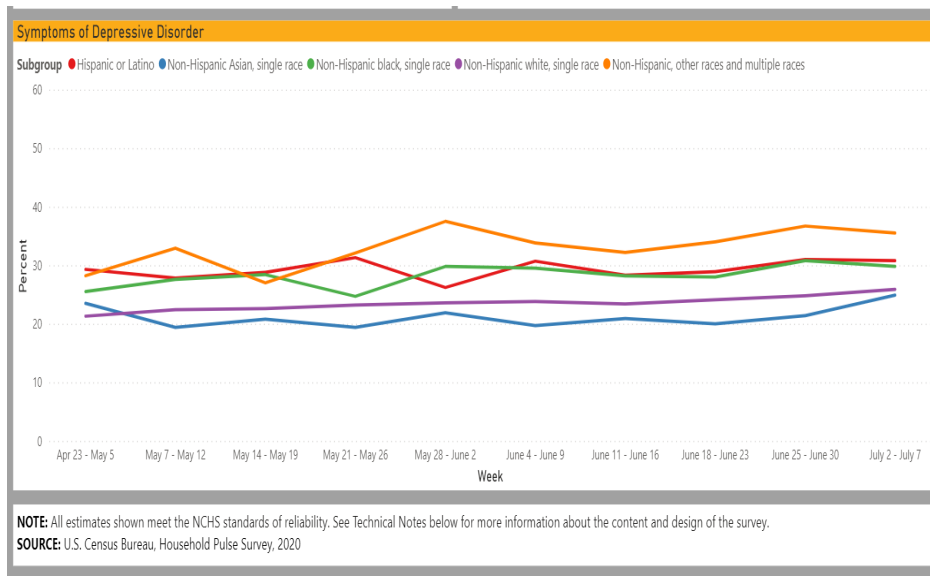
12

## Depressive Symptoms Since COVID by Age



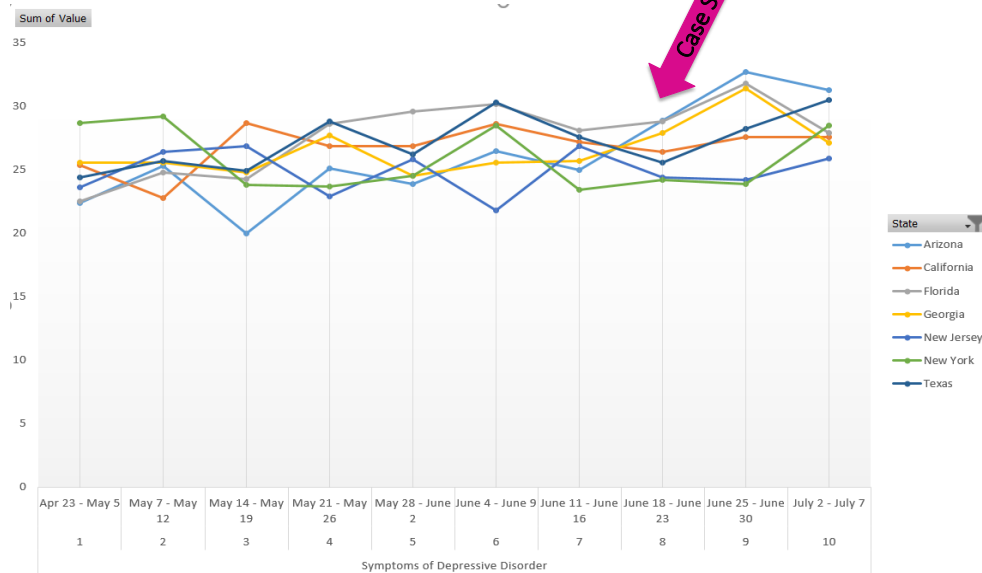
13

## Depressive Symptoms Since COVID By Race/Ethnicity



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## Depressive Symptoms Over Time By State



<https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>

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## PEW Research Center Survey

- ▶ PEW Research Center surveyed 4,133 individuals
  - Survey 1 (March 19, 2020 to March 24, 2020)
  - Survey 2 (April 7, 2020 to April 12, 2020)
  - Survey 3 (April 20, 2020 to April 26, 2020)
- ▶ Questions adapted from GAD-7, CES-D, Impact to Events Scale- Revised
- ▶ **33%** of surveyed adults reported high levels of psychological distress in March and April
- ▶ Significantly higher (**55%**) if individual experiencing financial distress

[https://www.pewresearch.org/fact-tank/2020/05/07/a-third-of-americans-experienced-high-levels-of-psychological-distress-during-the-coronavirus-outbreak/ft\\_20-05-04\\_coviddistress2/](https://www.pewresearch.org/fact-tank/2020/05/07/a-third-of-americans-experienced-high-levels-of-psychological-distress-during-the-coronavirus-outbreak/ft_20-05-04_coviddistress2/)

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## American Psychological Association Survey

- ▶ American Psychological Association (APA) updated their annual Stress in America survey to gauge monthly COVID impact
  - Survey 1 (April 24, 2020 to May 4, 2020)—3013 adults residing in the US
  - Survey 2 (May 23, 2020 to June 3, 2020)—3,013 adults residing in the US
  - Survey 3 Focused on Civil Unrest (June 9, 2020 to June 11, 2020)—2,058 adults residing in the US

<https://www.apa.org/news/press/releases/stress/2020/report>

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## APA Survey—May 2020 Findings

- ▶ **Higher levels of stress among American parents** (avg. score 6.7/10) vs non-parents (avg. score 5.5/10)
  - Managing remote/distance learning was a significant stressor for over 70% of parents
- ▶ Government response to crisis a source of stress for **7 out of 10** surveyed Americans
  - 73% Democrats, 67% Independents, 63% Republicans
  - 70% in US Northeast and Midwest, 64% in the US West, and 65% in the US South
- ▶ **70%** of surveyed Americans reported stress due to the economy/work
  - 68% responded similarly to the same survey in 2008
  - 46% responded similarly to the same survey in 2019
- ▶ **BIPOC reported higher levels of stress due to COVID**
  - Notably, significantly higher daily stressors noted by BIPOC adults compared to White adults (71% vs 59% related to “getting the coronavirus,” 61% vs 47% related to basic needs, and 59% vs 46% related to access to health care)

<https://www.apa.org/news/press/releases/stress/2020/stress-in-america-covid.pdf>

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### APA Survey—June 2020 Findings

- ▶ Government response to crisis a source of stress for **66%** surveyed Americans
  - 84% of this group reported stress from Federal response
  - 72% of this group reported stress from State response
  - 64% of this group reported stress from Local response
- ▶ **63%** of surveyed Americans reported stress from the nation reopening
  - 72% reported confidence that they can protect themselves from the coronavirus after reopening
  - 65% reported desire for more information once their community reopens
- ▶ **71%** of surveyed parents reported concern for their child's long-term development
  - 55% reported their child has been acting out since the start of the pandemic
  - 69% reported they were looking forward to school year ending
  - 60% reported they were struggling to keep their child occupied
  - However, 82% reported they were grateful for additional time with their children

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### APA Survey—June 2020 Findings on Civil Unrest Questions

- ▶ **83%** of surveyed Americans reported stress about the future of the nation
  - Previous high to this item on the same survey was 69% in 2018
- ▶ **55%** of Black Americans reported stress due to discrimination
  - Compared to 42% in the prior month

<https://www.apa.org/news/press/releases/stress/2020/stress-in-america-covid-june.pdf>

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## Notable Factors At Present

- ▶ Stress/trauma is ongoing
- ▶ Multiple sources of stress happening simultaneously
- ▶ Resurgence of cases—related stress about health, economy, social connections
  - Is it worse when you have to roll back than when you had to shut down?
- ▶ No change in vulnerability of BIPOC

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## Strategies for Supporting Patients

- ▶ Acknowledge current distress
- ▶ Ask about their emotional response/distress
- ▶ Explore symptoms and exacerbating stressors
- ▶ Assess heightened risk/suicidality
- ▶ If patient can be supported in the office:
  - Increase sense of safety by provided trusted resources
  - Practice self-soothing strategies
    - What has historically worked for the patient (breathing, going for a walk, yoga etc.)?
  - Encourage social connections
    - Is the patient aware of/using FaceTime/ Zoom?
  - Improving self-efficacy
    - Setting achievable goals and trying to meet them
  - Installation of Hope

<https://www.theschwartzcenter.org/media/MH-Providers-Working-with-Patients-Covid-198.pdf>

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## Community Resources

- ▶ **New York State Office of Mental Health Emotional Support Hotline**
  - 1-844-863-9314 | <https://omh.ny.gov/>
- ▶ **NYC Well**
  - Call: 1-888-NYC-WELL
  - Chat via their website: <https://nycwell.cityofnewyork.us/en/>
  - Text "WELL" to 65173 (message & data rates may apply when using the SMS service)
- ▶ **National Domestic Violence Hotline**
  - 1-800-799-SAFE(7233) | <https://www.thehotline.org/help/>
- ▶ **COVID Coach App**
  - <https://mobile.va.gov/app/covid-coach>
  - **FREE!**

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## Summary

- Various factors associated with emotional reactions to COVID
  - Fear for safety/health of self and loved ones
  - Financial distress
  - Isolation and disruption to routine; reduced social connections
  - Unique challenges and stressors for parents
- Notable national trends of COVID related stress, anxiety and depressive symptoms
  - Significant increase in reported anxiety and depression
  - Higher among BIPOC, parents, and individuals anticipating financial challenges
  - Notable increase in anxiety and depression around the resurgence of cases
  - Most surveyed Americans are worried about the present and the future
- Strategies and resources for supporting patients are available!

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## Questions?

## Stay in touch!

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# Telemedicine in the Era of COVID-19

Second Annual Best Practices Conference:  
Reconsidering Health Care in the Era of Pandemics

Icahn School of Medicine at Mount Sinai

August 11-13, 2020

Jay M Portnoy, MD  
Section of Allergy, Asthma & Immunology  
Medical Director of Telemedicine  
Children's Mercy Hospital  
Kansas City, MO

## Disclosures

- Speaker
  - Thermofisher

## Learning Objectives

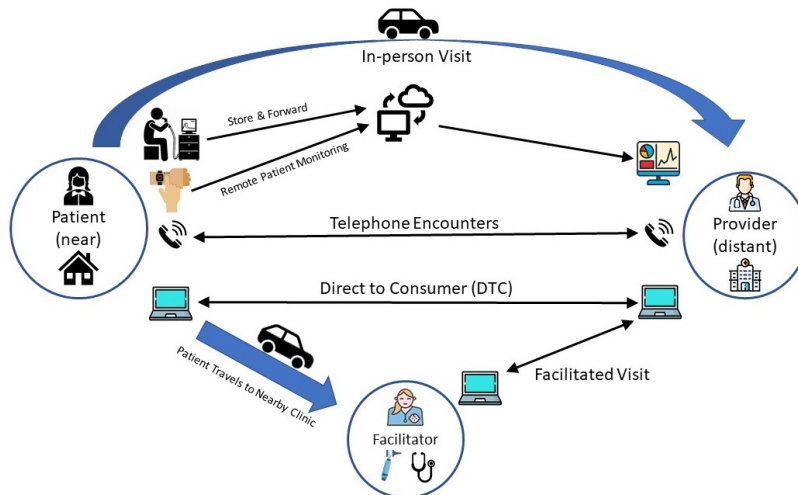
- The participant will be able to:
  - Set up a program for seeing patients by telemedicine
  - See and manage patients using telemedicine

## 10 Rules for Seeing Patients by Telemedicine

1. Determine the type(s) of Telemedicine you want to use
2. Learn telemedicine regulations
3. Select a platform
4. Build the infrastructure
5. Schedule telemedicine appointments
6. Get informed consent
7. Prepare for the visit
8. See the patient
9. Document the visit
10. Bill for the Encounter



## Rule 1: Types of Telemedicine



Portnoy JM, et al. J Allergy Clin Immunol. 2020;145(2):445-54.

## What Type of TM to Incorporate?

- In-Person visits
- Telemedicine visits:
  - Asynchronous
    - Store and Forward (PFTs, rashes, labs)
    - Remote Patient Monitoring (blood pressure, peak flows, steps, ACT)
  - Synchronous visits
    - Telephone Follow-ups
    - Direct to consumer 2-way video
    - Facilitated virtual visits 2-way video with exam equipment
    - Inpatient Consults

## Asynchronous: Remote Patient Monitoring

- Digital inhalers for albuterol and inhaled corticosteroids
- Albuterol- monitoring can be used as a diagnostic test
  - Proxy for asthma symptoms
  - Can monitor control
- ICS- monitoring can be used to monitor treatment
  - Proxy for adherence
- Could be used to learn what works to control asthma in the real world



## Telemedicine Visit Types

### Facilitated Visit



- When a physical exam is required
- To bill for an initial visit
  - For certain medical conditions (eg: otitis media, acute asthma)
  - Uses the provider's equipment

### Direct to Consumer



- When a physical exam is not required
- For urgent care visits- can be definitive treatment or can serve as triage
  - For established patients –an exam is not necessarily required
  - Uses patient's equipment
  - Can do a cursory exam depending on the patient's equipment

## Inpatient Consults

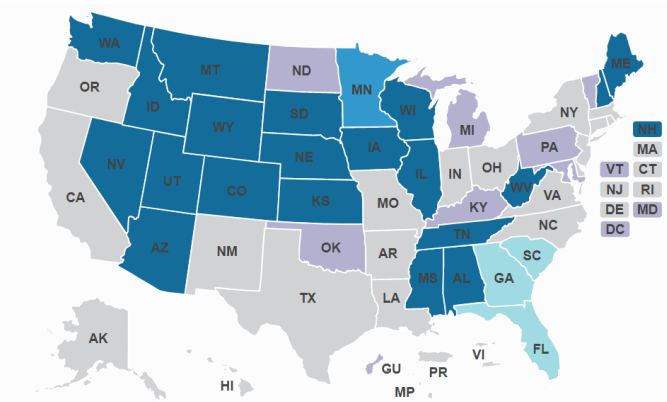
- Many (particularly rural) hospitals have infrastructure to accommodate inpatient consults
- They also are looking for specialty services that might be deficient
- You might contact hospitals in rural areas and ask if you could provide specialty inpatient consults.
  - They would provide the equipment
  - They would take care of credentialing
- Your local hospitals might also be willing to accommodate consults by TM

## Rule 2: Learn telemedicine regulations

- You need to be licensed in the state where the patient is located.
  - During COVID-19 some states have waived this requirement for telemedicine.
  - The waivers expire at various times so you need to check regularly
- CPT codes for new patients require a physical exam
  - For an established patient, you only need 2 of the 3 components (history, physical exam, decision making)
- Relaxation of HIPAA regulations (March 6, 2020)
  - Permits providers to use their personal devices to see patients.
- Requirement that a physician and patient have an established relationship waived by CMS (March 19, 2020)
  - Physicians can treat either New or Established patients via telehealth or telephone and are billable.

# Interstate Medical License Compact (IMLC)

- The IMLCC is an agreement between 28 states, the District of Columbia and the Territory of Guam where physicians are licensed by 41 different Medical and Osteopathic Boards.
- Licensed physicians can qualify to practice medicine across state lines within the Compact if they meet the eligibility requirements.
- Approximately 80% of physicians meet the criteria for licensure through the IMLC.
- The Application process is expedited by leveraging the physicians existing information previously submitted in their state of principal license (SPL).
- The SPL will verify the physicians information and conduct a fresh background check.
- Once qualified the Physician may select any number of Compact states for which they desire to practice



- = Compact Legislation Introduced
- = IMLC Member State serving as SPL processing applications and issuing licenses\*
- = IMLC Member State non-SPL issuing licenses\*
- = IMLC Passed; Implementation In Process or Delayed\*

\* Questions regarding the current status and extent of these states' and boards' participation in the IMLC should be directed to the [respective state boards](#).



## States Waiving Licensure Requirements/Renewals in Response to COVID-19

March 31, 2020

State	Note	Citation
Alabama	The Alabama Board of Medical Examiners and the Medical Licensure Commission have adopted emergency administrative rules and procedures allowing for the emergency licensing of qualified medical personnel. These measures will allow physicians and physician assistants who possess full and unrestricted medical licenses from appropriate medical licensing agencies to apply for and receive temporary emergency licenses to practice in Alabama for the duration of the declared COVID-19 health emergency.  No changes related to licensing or renewals.*	<a href="#">Alabama Press Release Board of Med Guidance Temporary Emergency License Requirements State Resource Page</a>
Alaska*	A pending bill in the Legislature, SB 241, says, in part, "... Notwithstanding any other provision of law, during the public health disaster emergency declared by the governor... a professional or occupational licensing board... may grant a license, permit, or certificate on an expedited basis to an individual who holds a corresponding license, permit, or certificate in good standing in another jurisdiction to the extent necessary to respond to the public health disaster emergency. A license expedited under this section expires on the earlier of September 1, 2020; or the date the governor determines... that the public health disaster emergency no longer exists..."  * For as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met: 1) The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice 2) Is conducted using an audio-visual, real-time, two-way interactive communication system. 3) The practitioner is acting in accordance with applicable federal and state law  Allows ADHS to waive licensing requirements to provide healthcare officials with assistance in delivering services during times of heightened demand.	<a href="#">Emergency Declaration</a>  <a href="#">AK SB 241</a>  <a href="#">Guidance re: Telemedicine</a>  <a href="#">State Resource Page</a>
Arizona	The Director of the Arizona Department of Health Services, pursuant to the Declaration of Emergency issued by the Governor... may establish... a process for the temporary waiver of the professional licensure requirements necessary for the implementation of any measures... establish requirements for registering providers with out-of-state licenses who will be permitted to provide services in Arizona with out-of-state licenses...  * A state agency or board that licenses individuals or entities as indicated herein shall: a) Defer requirements to renew licenses that have an expiration date between March 1, 2020 and September 1, 2020 by six months from the expiration date, unless those requirements can be completed online; b) Defer requirements to complete continuing education by six months; c) Suspend any rules that prevent or limit the amount of online or alternative learning hours permitted to issue or renew a license...  No changes related to licensing or renewals.	<a href="#">Press Release</a>  <a href="#">Dept. of Health Services Admin. Order</a>  <a href="#">Executive Order 2020-17 re: CME/Renewals</a>  <a href="#">State Resource Page</a>
Arkansas*	* In an effort to assist with the COVID-19 health crisis, the Arkansas State Medical Board voted to grant emergency temporary licenses to Arkansas medical residents who have completed at least one year of postgraduate training and have the written recommendation of their program director.  Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparation for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code section 1795. The EMS Authority will only accept requests for out of state medical personnel approval from a California medical facility, telehealth agency contracted with a California medical facility or a staffing agency providing staffing to California medical facilities, that intends to utilize these resources.  * A medical facility, telehealth agency or staffing agency which desires to utilize medical professionals with out-of-state certifications or licenses during the COVID-19 State of	<a href="#">Emergency Temporary Application</a>  <a href="#">State Resource Page</a>  <a href="#">Emergency Declaration</a>  <a href="#">Temporary License Application</a>
California		

## Rule 3: Select a platform

Feature	Description	Used for which type of TM
2-way video	Patient and provider can see and hear each other in real-time	Synchronous DTC and facilitated visit
Multipresence	More than 1 provider and/or patient can participate at a time.	When parents are at a different location than their child. To invite a consultant to participate
Mobile Apps available	Permits patients and providers to participate in video conferencing using a smart phone or tablet when a computer is not available Permits tracking of biomarkers	Synchronous DTC and facilitated visit Remote patient monitoring and e-diaries for tracking patient-generated information
Screen Sharing	Permits providers to show information to patients including test results and instructions Permits patients to show information to providers such as pictures and symptom charts	Synchronous DTC and facilitated visits
Digital Exam Transmission	Permits output from digital exam equipment to be viewed by a provider Can be used to send pictures and patient data to providers.	Facilitated visits DTC if the patient has exam equipment Store & forward and RPM.
Integrated environment	The platform is integrated into the provider's Electronic Health Record. Permits scheduling of appointments, billing and other administrative tasks	Synchronous DTC and facilitated visits
HIPAA Compliant	Transmits information to and from provider in a secure manner consistent with HIPAA regulations.	Any TM activity should be HIPAA compliant

## Rule 4: Build the Infrastructure

- Internet connection
  - Reliable, low latency
- Equipment
  - Double monitor or iPad with monitor
  - Embedded in EHR
  - Digital exam equipment for facilitated visit
- Professional looking background



## Rule 5: Schedule appointments

- Determine whether the patient has DTC ability
  - Internet connection, computer, tablet or smart phone
- Send appointment invite by e-mail with link
- Instructions to send in advance:
  - Preregistration information online if needed
  - Download any needed app prior to the visit
  - A web site or phone number if assistance is needed
  - Please cancel or reschedule if unable to keep the appt.

## Rule 5: Schedule appointments

- Instructions for the visit:
  - Ask that the patient (if a child) be present during the visit
  - Log in 10 minutes early to make sure that the equipment works
  - Location for the visit should be quiet and private
  - Keep video on during the visit
  - Don't multitask (do other things) during the visit
  - Phone number to call if there are problems

## Rule 6: Get informed consent

- Medicaid rules: The patient must consent to being seen by telemedicine
  - Can be obtained either by the referring, consulting or distant site provider
  - Consent can be written or verbal. It needs to be documented either way.
- Should include:
  - What TM is
  - The expected benefits
  - Possible risks associated with it
  - Security measures that will be used to protect patient privacy
  - Option to decline a telemedicine visit
- Generally valid for 1 year
- Samples available at <http://telehealthresourcecenter.org/>

## Rule 7: Prepare for the visit

- Pretty much the same way you prepare for an in-person visit
- Review records including electronic records obtained before the visit
  - Includes ACT, labs, etc...
- Encourage the patient to sign up for a portal in advance

## Rule 8: See the patient

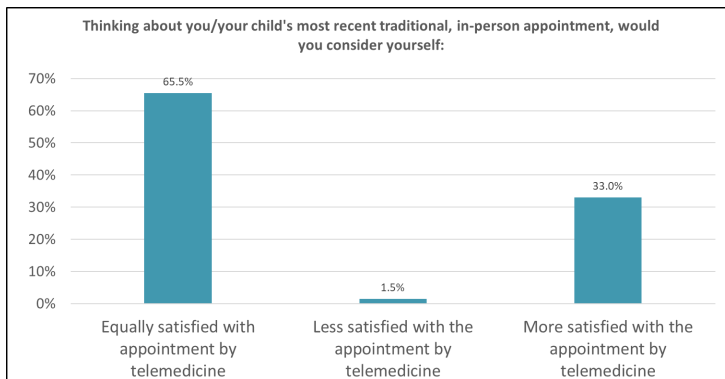
- Verify that you can be seen and heard
- State your location and verify the patient's location
  - Must be in a state where you are licensed to practice or where there is a waiver
- Look into the camera when talking to the patient
  - If you need to look away, explain what you are looking at
- Can review labs and other documents by sharing your screen
- Most telemed visits are shorter than in-person visits
  - They tend to be more goal focused, less chit chat
  - Patients are OK with this. They tend to speak less.

## Satisfaction Survey

Question	Strongly Agree	Mostly Agree	Neutral / No Opinion	Mostly Disagree	Strongly Disagree	Total
1. The room was comfortable for my visit with the provider.	50	7	2			59
1. It was easy to see the provider throughout our conversation.	55	3				58
1. It was easy to hear the provider throughout our conversation.	52	7				59
1. The provider was looking directly at me when it was appropriate.	56	2				58
1. It was easy to understand the provider's instructions.	55	3	1			59
1. I had all the materials needed to manage my child's healthcare	54	4				58
1. I understand the provider recommendations I received today.	55	3	1			59
1. My provider really seemed to care about my child and me.	53	5	1			59
1. I was provided an opportunity to ask questions.	56	3				59
1. It was important that my child have today's evaluation.	50	4	1			55
1. The distance I had to travel to see the provider was acceptable.	53	4		1		58
1. The appointment using telemedicine was as good as an appointment in person.	47	7	4			58
1. Not having to travel to Kansas City for this appointment is important to me.	46	8	3		1	58
1. After my experience today, I would recommend health care appointments by Telemedicine	51	4	3			58
Mean Count	52.4	4.6	2.0	1.0	1.0	

Ann Allergy Asthma Immunol 117 (2016) 241e245

## Patient Satisfaction



### • Themes

- Distance/convenience
- Curious about telemed
- Likes telemed staff
- Likes telemed technology
- Positive experience with it
- Quicker appt time
- Best way to see the same provider

## Rule 9: Physical exam

- For a facilitated visit
  - Instruct the facilitator to activate the desired
  - Parts of the exam (eg: palpation) can be done by the facilitator with results observed or reported to the provider
- For direct-to-consumer visit
  - Ask the patient to show you rashes or other findings that can be seen with their equipment
  - You can document an exam with what is observed

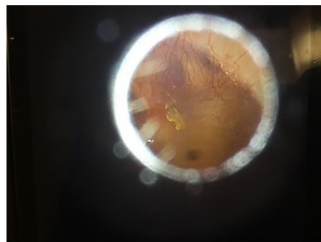
## Physical Exam



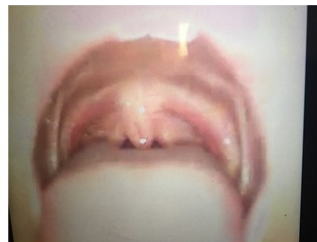
Digital Otoscope



Digital Stethoscope



Tympanic Membrane



Oropharynx

## Exam that can be done by DTC

- **Exam:**
- **Vital signs:** Weight-      Height-      Resp Rate-      Pulse-
- **General:** No apparent distress. Awake, alert, well-appearing.
- **HEENT:** Normocephalic and atraumatic. Mucous membranes are moist. No periorbital edema. Facial muscles move symmetrically.
- **Neck:** Neck is symmetrical with trachea midline.
- **Eyes:** Conjunctiva and eyelids normal bilaterally. Pupils equal and round bilaterally.
- **Respiratory:** breathing unlabored, no tachypnea.
- **Cardiovascular:** No edema, no pallor, no cyanosis.
- **Abdomen:** Non-distended.
- **Skin:** No concerning rash or lesions observed on exposed skin.
- **Extremities:** Normal range of motion observed. No peripheral edema.
- **Neuro:** Mood and behavior appropriate for age.
- **Musculoskeletal:** Symmetric and appropriate movements of extremities.



## Rule 10: Bill for the encounter

- 39 states and DC have laws that govern private payer telehealth reimbursement policies.
- Kansas, Iowa and Utah passed telehealth private payer reimbursement legislation, although they all don't go into effect until Jan. 1, 2019.
- Only a few private payer laws require that the reimbursement amount for a telehealth-delivered service be equal to an in-person visit.
- Kansas included a provision that ensures insurers are not requiring patients to utilize telemedicine in lieu of receiving in-person services from an in-network provider.

## Codes to use

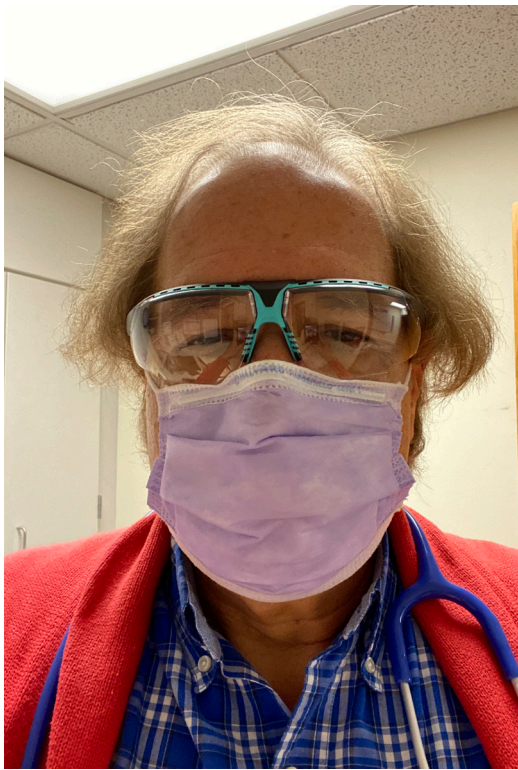
- Telephone services
  - 99441 5-10 minutes of medical discussion
  - 99442 11-20 minutes of medical discussion
  - 99443 21-30 minutes of medical discussion
- Online Digital E&M services
  - 99421 5-10 minutes (over a seven day period)
  - 99422 11-20 minutes (over a seven day period)
  - 99423 21 or more minutes (over a seven day period)
- Remote monitoring
  - **99453** Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
  - **99454** device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days (provided monitoring occurs during at least 16 days during the 30-day period)
  - **99457** Remote physiologic monitoring *treatment management services*, clinical staff/physician/other qualified health care professional time in a calendar month requiring *interactive communication* with the patient/caregiver during the month; first 20 minutes.
  - **99458** each additional 20 minutes

## G Codes

- Used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes
- **G2010** was in the 2019 physician fee schedule and is used for remote evaluation of established patient's submitted videos or still images
- **G2012** was also included in the 2019 physician fee schedule.
  - It has been referred to as a "Virtual Check-in."
  - It is considered to be a call or video check in to see if an E/M visit is needed

## FACE-TO-FACE Telehealth Patient Visits

- The usual E/M visit codes (99201-99215) apply
- Telemedicine E/M visits are coded just as an in-office E/M visit would be but with the addition of a modifier
- Time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes
  - (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215).
- Telemedicine waivers include:
  - Evaluation of new patients via telehealth
  - Beneficiaries living in any geographic area and accessing telemedicine from their homes
  - Use of smartphones and audio only connections for some services.



## Enjoy Telemedicine and stay safe

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“The only infection you can get when using telemedicine is a computer virus”

Jay M Portnoy, MD

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# Technology and Aging Adults: Opportunities in a Pandemic

Sara J Czaja PhD  
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Director, Center on Aging and Behavioral Research  
Weill Cornell Medicine

## Purpose and Objectives

### PURPOSE

*Demonstrate how technology applications can be used to help remediate problems with social isolation and access to resources among aging adults and informal caregivers.*

### OBJECTIVES

- Discuss challenges for aging adults and informal care providers during the COVID-19 pandemic.
- Discuss how technology applications can be used to help remediate these challenges.
- Provide examples of ongoing research at Weill Cornell Medicine.

### FINANCIAL DISCLOSURE

*I am a Co-Chief Scientific Officer of i-Function Inc. My presentation will not include any references to i-Function.*

## Overview

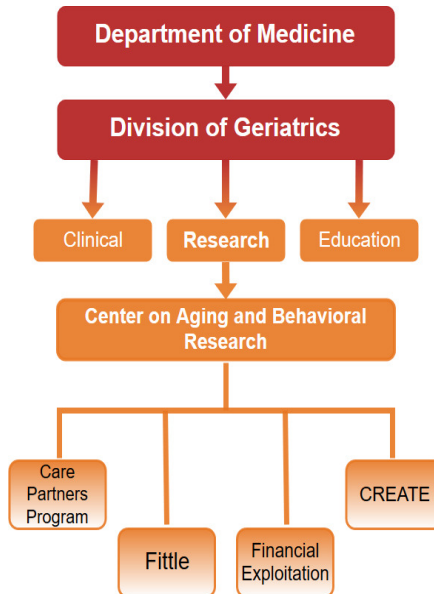
- Provide a brief overview of the challenges associated with the COVID-19 pandemic for aging adults and informal caregivers.
- Discuss the potential of technology applications in meeting these challenges.
- Provide examples of on-going research in the Center on Aging and Behavioral Research
  - PRISM Project
  - Care Partners Program
  - Fittle
- Highlight important next steps.

## Center on Aging and Behavioral Research

- Conduct research to understand factors/contexts that foster “successful aging.”
- Conduct research to develop efficacious strategies to enhance the quality of life for older adults and their families and address the challenges of aging.
- Provide training opportunities for students and junior faculty.
- Foster collaborations with the community and older adults.
- Foster collaborations with other researchers.



## Center on Aging and Behavioral Research



## Special Challenges of COVID-19

- The COVID-19 pandemic presented some special challenges for aging adults and their families.
- “Stay at Home” and “Pause Requirements”:
  - Drastically diminished older adults’ opportunities for cognitive, social, and physical engagement.
  - Limited access to routine medical care, social support networks, and structural supports such as group meals, activities.
  - Limited informal caregivers access to resources and support.
  - Increased problems with **social isolation and loneliness**.



Center on Aging  
& Behavioral Research

## Some Definitions

- **Loneliness**
  - a subjective, negative feeling related to a person's perception and experience of deficient social relations.
- **Social Isolation**
  - an objective state, social isolation arises in situations where a person is lacking people with whom to interact.
- **Social Networks**
  - Structural construct - Interconnected webs of relationships.
- **Social Engagement**
  - ✓ Degree of a person's participation in community or society
    - ✓ Personal (family and friends)
    - ✓ Community/Neighborhood (senior center)
    - ✓ Societal (contributions; social causes)

## Social Isolation and Loneliness

- Prevalence of loneliness and social isolation among older adults:
  - Estimates indicate that about 25-30% of older adults suffer from loneliness
  - > 8 million older adults are isolated (AARP)
- Adults especially at risk for being socially isolated and experiencing problems with loneliness:
  - Oldest old
  - Disabilities –e.g., mobility impairments, hearing impairments
  - **Live alone or Assisted Living or Skilled Nursing Facilities**
  - Lower SES status
  - Informal caregivers
- Impact of social isolation/loneliness:
  - Lack of access to needed services, resources, and support
  - Poorer physical, cognitive, and emotional health status and increased risk for mortality
  - Diminished quality of life

## How can Technology Help?

- Technology offers the potential of increasing social support, and connectivity :
  - Access to information and services

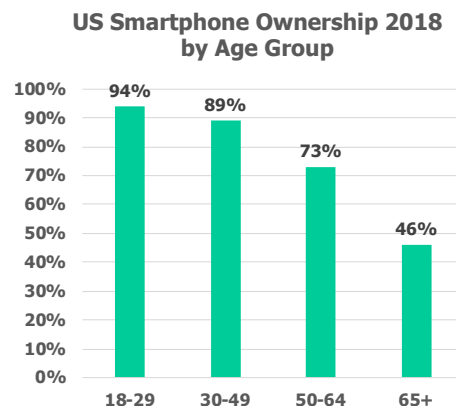
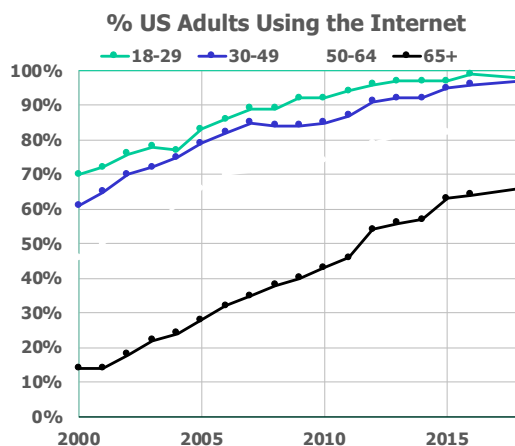


- Increased opportunities for social interactions & social support: family, friends, new acquaintances, social robots



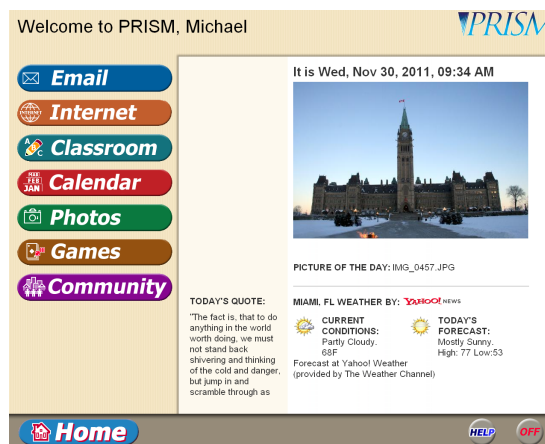
- Increased recreational, educational, and employment opportunities
  - Telework/Mentoring
  - Online learning programs
  - Games, hobbies

## US Internet & Smartphone Use



# CREATE: Cross-Site Project

## A Personal Reminder Information and Social Management System (PRISM) Designed for Older Adults



## Specific Aims

- Obtain information on the usefulness and usability of the PRISM system and interface design issues among a diverse sample of older adults who were “at risk” for social isolation.
- Examine the impact of access to the PRISM system on:
  - Social isolation
  - Social support
  - Well-being
- Examine the impact of access to the system on:
  - Computer attitudes
  - Computer self-efficacy
  - Technology adoption
- Gather longitudinal data on study outcomes.
- Gather data on usage patterns and features that are the most useful.
- Gather data on the relationship between individual characteristics and system use.

### Findings (Czaja et al. 2018)

- Sample: 150 Computer Naïve Older Adults Aged 65-98 yrs.
- Able to successfully train all participants on PRISM.
- Reported Benefits of using PRISM:
  - Communicate with family members (grandchildren, children)
  - Reconnect with past (e.g., happenings in hometown)
  - Renewed friendships and new friends through the “buddy system”
  - Opportunities for new learning
  - Find information related to health, resources other interests
  - Fun, entertainment – games
- Continued use of PRISM throughout the 12 months (~ 4 days/wk.)

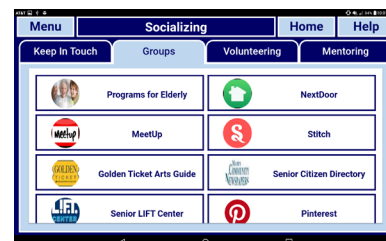
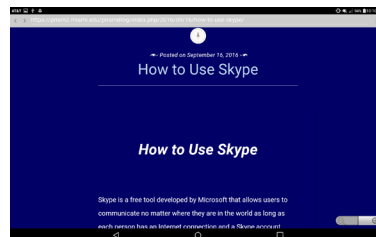
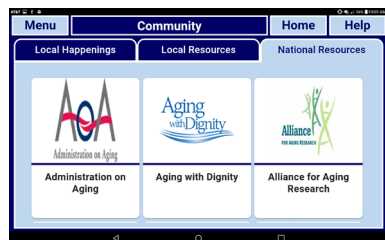
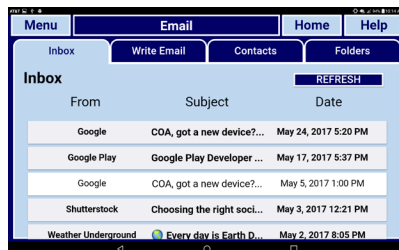
### Findings (Czaja et al., *The Gerontologist* 2018)

- Changes in Outcomes in the Expected Direction:
  - Increase in Social Support ( $p < .01$ )
  - Decrease in Loneliness ( $p < .05$ )
  - Increase in Well-being ( $p < .05$ )
  - Increase in Comfort with Computers ( $p < .001$ )
  - Increase in Computer Efficacy ( $p < .001$ )
  - Increase in Computer Proficiency ( $p < .01$ )



## CREATE: PRISM 2.0


- Evaluate the efficacy of an enhanced version of PRISM in terms of reducing loneliness and enhancing social connectivity among diverse populations of older adults in different contexts:
  - Rural locations: FSU
  - Senior Housing: University of Illinois
  - Assisted Living Facilities: University of Miami
  - Urban locations: Weill Cornell Medicine
- Evaluate the usefulness and usability of PRISM 2.0.



HRF 1811219736

HRF 1811219736  
Approval Date: 02-04-2020  
Expiration Date: 02-03-2021

## Think you are having memory problems?



The Weill Cornell Medicine Center on Aging and Behavioral Research is conducting a research study aimed at improving the quality of life of older adults. The study has a duration of 5 months.

You may be eligible to participate if you are:

- 65+ years old
- English speaking
- Experiencing mild memory loss

Eligible participants will receive:

- A tablet computer with Internet access
- One-on-one training sessions on how to use the tablet computer
- Compensation for completion of assessments

For more information, please contact us directly at:  
646-962-7141 or  
AgingBehavioralRsrch@med.cornell.edu

**Weill Cornell Medicine**  
Center on Aging  
& Behavioral Research

## Quotes from PRISM Participants

"I am able to constantly be in touch with friends and family and see them, play games on it"

"I love using PRISM. It enabled me to brighten my day with knowledge every day. Shopping. Games."

"It went beyond my expectations. I mean, I look forward to get on PRISM every day. I wake up in the morning, Candy Crush, and then during the day I'm looking up different things, different art techniques. It really has helped me a lot."

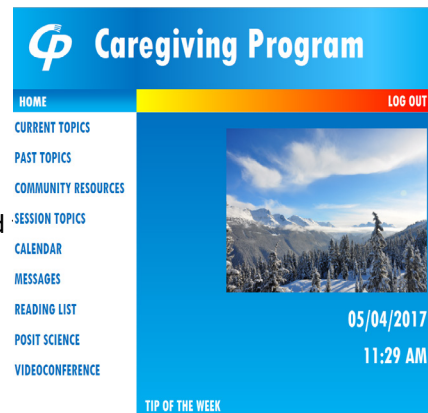
## Family Caregiving: Care Partners Program (NIH/RO1)

### Evaluating:

- An innovative technology-based intervention designed to improve the quality of life for family caregivers and patients with early stage Alzheimer's disease.

### Intervention:

- Delivered at home via technology
- Caregiver component
- Patient component
- Joint component for the caregiver and
- Features:
  - Videoconferencing skill building sessions
  - Blog
  - Educational and skill building videos
  - Information about resources
  - Pleasant events videos
  - Cognitive training
  - Videoconferencing support groups



 **Weill Cornell Medicine**  
Center on Aging  
& Behavioral Research

## Innovation

- The intervention approach is dyadic – includes both the CG and CR.
- The intervention is delivered in the home using computer laptops.
- Internet access is provided for the duration of the study.
- Caregivers are compensated for participation and “get to keep the technology at the study end.”
- The focus is on the CG in the early stage of the caregiving trajectory.
- Both components of the intervention represent non-pharmacological treatment approaches.
- The intervention is culturally tailored and is being evaluated with diverse populations and available in English and Spanish.

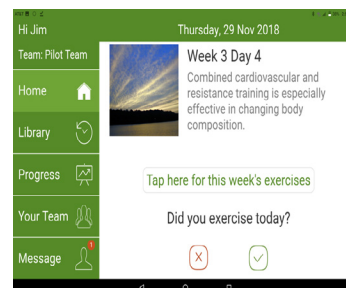
## Intervention Overview

- Caregiver Component:
  - ◆ Focus on early stage caregivers
  - ◆ Prepare the caregiver and help transition to the caregiver role
  - ◆ Prevent caregiver distress
  - ◆ Multicomponent
- Care Recipient Component:
  - ◆ Cognitive training
  - ◆ Compensatory strategies
  - ◆ Functional/Life skills
- Integrated Component:
  - ◆ Communication
  - ◆ Stress Management
  - ◆ Pleasant Events
  - ◆ Well Being

## Physical and Social Wellbeing: Fittle (NIH)

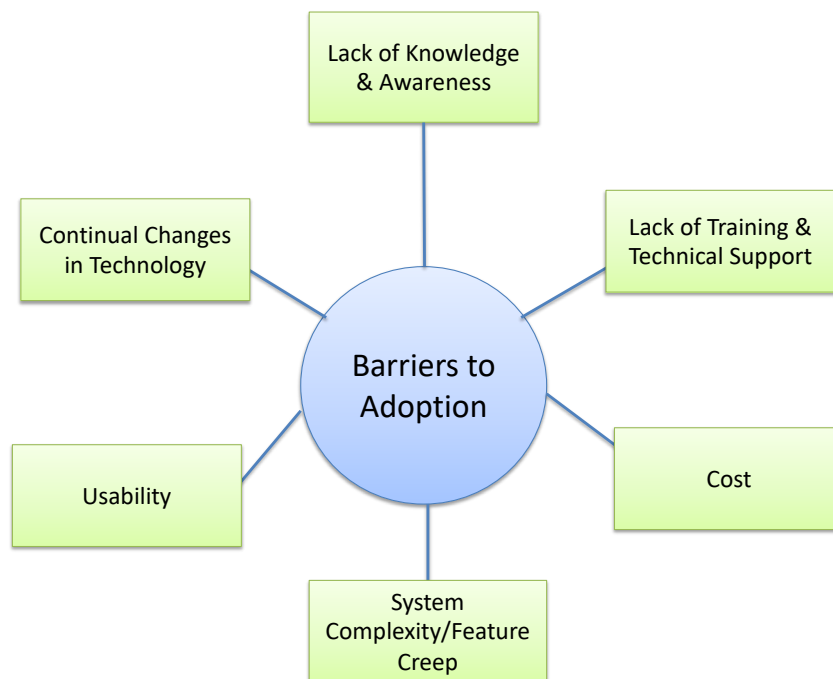
Evaluating:

- the usability and efficacy, for diverse older adults, of a new computer tablet-based system that provides:
  - personalized programs for enhancing physical activity, and social engagement
  - the program is tailored to the individual's fitness level
- participants are part of teams and receive motivational feedback
- individuals are trained with their team and the program is administered at home on computer tablet.



## Summary

- Technology holds promise in terms of enhancing social connectivity/support for older adults however:
- A stronger evidence based is warranted on the effectiveness of technology-based interventions aimed at alleviating social isolation
  - Need to include diverse samples of older adults
- Issues such as privacy concerns, training protocols, potential negative impact of ICTs need to be addressed.
- We need to ensure that diverse populations of older adults have *meaningful access* to information and communication technologies (ICTS).
  - Research - needs, preferences, challenges, benefits of diverse populations of older adults.
  - System Designers - ensure systems and applications are useful, usability and instructional support
  - Policy – ensure access







# **Weill Cornell Medicine**

## **Center on Aging & Behavioral Research**

**Call: 646: 962 -7141**

### **Contact Information**

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Weill Cornell Medicine

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646-962-7148

# National Organizing of Volunteers & Resources – Managing Patient Surge During a Pandemic

Marc Napp, MD, MS  
Senior VP, Medical Affairs  
Deputy Chief Medical Officer  
Mount Sinai Health System

**Second Annual Best Practices Conference:**  
Reconsidering Health Care in the Era of  
Pandemics

August 11, 2020



## PURPOSE

To describe the approach that MSHS used to address the insufficiency of health care resources for the COVID-19 surge

## OBJECTIVES

- Review the natural characteristics of the COVID-19 pandemic that hampered health care workers' efforts to provide optimal care
- Consider operational challenges that impeded our ability to achieve optimal health outcomes for hospitalized COVID-19 patients
- In the wake of the COVID-19 surge and the modified health care delivery models that we implemented, examine the impact of tiered resource distribution and its consequences
- Discuss the methodology that was developed to ration scarce resources in the event that the surge outstripped those resources

## FINANCIAL DISCLOSURE

None

## Agenda

1. Planning & Reacting
2. Implementation
3. Scarce Resource Allocation

## Planning & Reacting

Thursday, March 5, 2020

## MSHS Emergency Operations Center



## Emergency Operations Center Workgroups

- ▶ Crisis Standards of Care
- ▶ Crisis Communications
- ▶ Supply Chain
- ▶ Staffing
  - ▶ Nurses, Respiratory Therapists, Lab Techs . . .
  - ▶ Physicians, PAs, NPs, CRNAs
- ▶ Policy (non-clinical)
- ▶ Information Technology
- ▶ Blood Bank & Laboratory
- ▶ Support Services (Environmental Services, Environmental Health & Safety, Real Estate, Engineering, Security, Transportation)
- ▶ Discharge Planning

## Emergency Operations Center Workgroups

- ▶ Crisis Standards of Care
- ▶ Crisis Communications
- ▶ Supply Chain
- ▶ Staffing
  - Nurses, Respiratory Therapists, Lab Techs . . .
  - Physicians, PAs, NPs, CRNAs
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- ▶ Information Technology
- ▶ Blood Bank & Laboratory
- ▶ Support Services (Real Estate, Engineering, Security, Environmental Services, Environmental Health & Safety, Transportation)
- ▶ Discharge Planning

Monday, March 23, 2020

## Situation Status

- ▶ We're already in crisis mode
  - >50% of beds occupied by COVID-19 patients
  - ICUs are full
  - Hospitalists are becoming exhausted
  - EDs with thin night-staffing are overwhelmed
- ▶ Some departments may be hiding their available people
  - Don't want them reassigned & deployed
  - Don't want them sick in the event that they're needed for the recovery phase
  - MIA
- ▶ Hospitals are creating their own labor pools for internal redeployment, then looking to the Health System for unfilled needs
- ▶ Alternate care & staffing models
  - Switch from shift assignments to longitudinal assignments
  - Increase patient:staff ratios
  - Engage the voluntary physicians
- ▶ Focus on critical staff
  - Emergency Departments
    - Emergency Medicine Physicians & APPs
  - Medicine Units
    - Hospitalists
    - Med/Surg Nurses
    - Acute Care APPs
  - Critical Care
    - Intensivists
    - Critical Care Nurses
    - Critical Care APPs
  - Respiratory Therapists
  - Palliative Care Physicians & Social Workers
  - Behavioral Health
- ▶ Consider breadth of the demand
  - 8 hospital campuses
    - 3 largely voluntary
  - Ambulatory sites
  - On-site supportive care



Monday, March 23, 2020

## Governor Cuomo to NY Hospitals:

*You must increase your capacity by 50%. You must. Mandatory directive from the state. Find more beds, use more rooms. You must increase your capacity 50%.*

### Total

### Capacity

	Pre-COVID Total Beds
MSH	939
MSM	292
MSW	256
MSBI	158
MSQ	143
MSB	209
MSSN	294
<b>System</b>	<b>2291</b>

## Workstreams

### LIP Labor Pool

- Physicians
- Physician Assistants
- Nurse Practitioners
- Residents & Fellows

### Staffing Demand

- Acute
- Forecasted

### Alternative Staffing/Care Models

### Training-Up

- Emergency Medicine
- Pulmonary Medicine
- Critical Care
- Palliative Care

## LIP Labor Pool

### Sources

- ▶ MS Doctors Faculty Practice
- ▶ MSHS Website Volunteer Portal
- ▶ Medical Staff Services Database
- ▶ School Labor Pool
- ▶ Develop "smart" database of staff resources who can be strategically deployed
  - Individual skillsets
  - Availability
    - Personal & operational conflicts
  - Site familiarity
- ▶ Include:
  - Full-time staff
  - Voluntary staff
  - APPs
  - Students
  - Non-clinical staff

## Staffing Demand

- ▶ Emergency Medicine
  - System Vice Chair
- ▶ Hospital Medicine
  - MSQ Network Designee
  - MSH Hosp & Crit Care Leads
  - MSM Hosp & Crit Care Leads
  - MSW Hosp & Crit Care Leads
  - MSBI Hosp & Crit Care Leads
  - MSB Network Designee
  - MSSN CMO Representative
- ▶ Pulmonary / Critical Care
  - System Division Chief
- ▶ Palliative Care
  - System Chair
- ▶ Detailed, real-time awareness of LIP staffing requirements
- ▶ 24-hour look back & look ahead
- ▶ Operational Leads, Site Chairs and Division Chiefs have hands-on involvement in acute & forecasted staffing needs
- ▶ Utility Player: CRNAs
  - Critical Care Nursing
  - Nursing Education
  - Respiratory Therapy
  - Rapid Response Teams
  - Intubation Teams
  - Ventilator Management

## Alternative Staffing/Care Models

Recognizing that we are faced with . . .

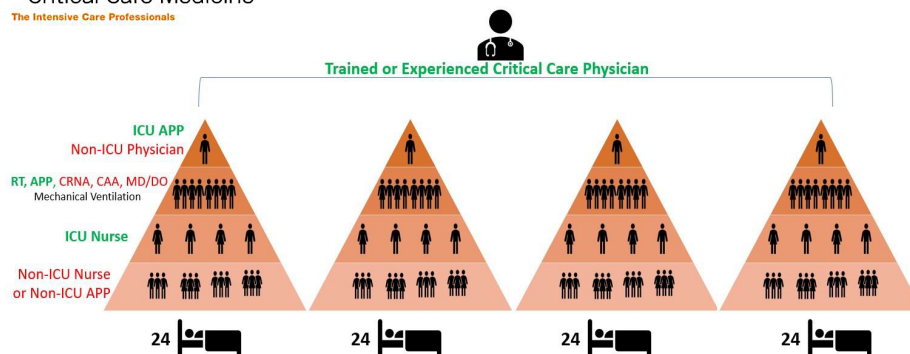
- ... Shortages of Emergency Medicine Physicians, Intensivists, Hospitalists, Palliative Care Practitioners & APPs
- ... Relying on practitioners without the necessary clinical skills and expertise
- ... Soaring numbers of patients

We must consider alternative staffing/care models

- Longer longitudinal assignments
- Unit-anchored (geographic) assignments
- Plug & play slot coverage
- Pre-assembled care teams
  - Clinical Captain
  - MD
  - APP
  - Resident
  - Nurse
  - PCT

## Tiered Staffing Model for Respiratory Pandemic

Society of  
Critical Care Medicine  
The Intensive Care Professionals



Modified from the Ontario Health Plan for an Influenza Pandemic Workgroup. *Critical Care During a Pandemic*.

<https://www.sccm.org/getattachment/Blog/March-2020/United-States-Resource-Availability-for-COVID-19/United-States-Resource-Availability-for-COVID-19.pdf?lang=en-US>

## Train-Up

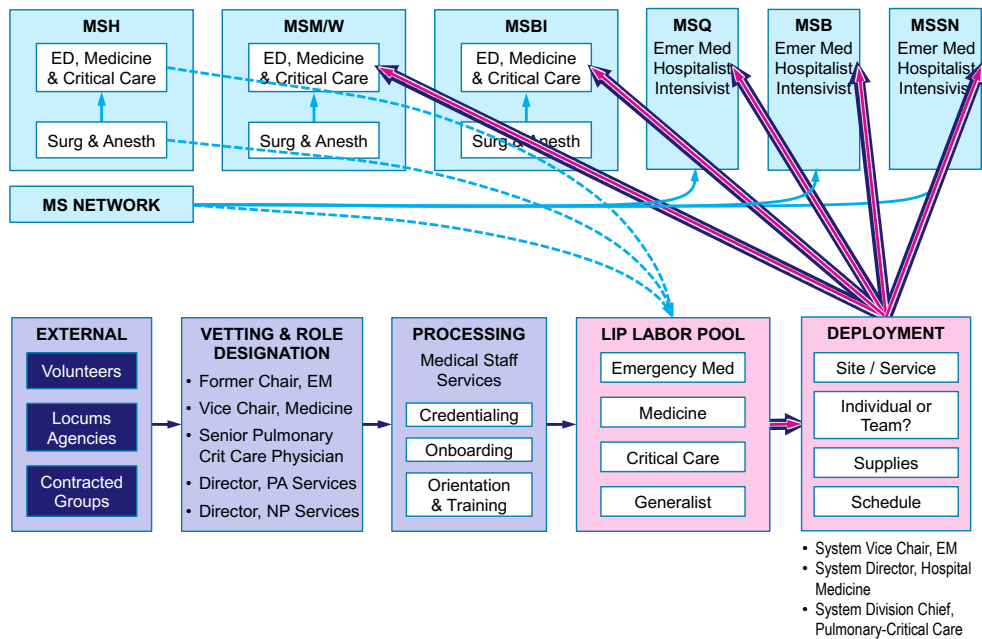
- ▶ Talent Development & Learning
  - Emergency Medicine
  - Pulmonary Medicine
  - Critical Care
  - Palliative Care
  - Graduate Medical Education
  - Nursing Education



Objective: Train-up LIPs to practice outside their usual scope

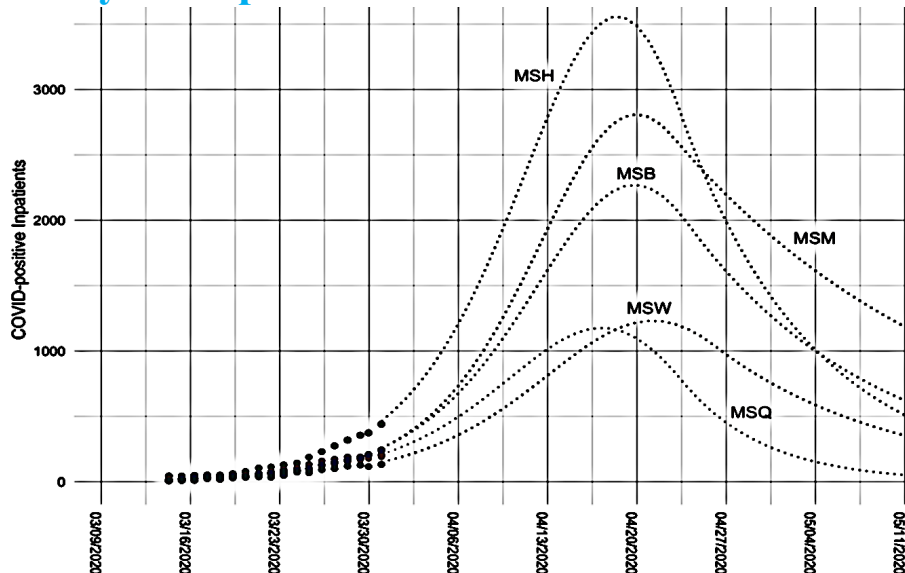
1. Enumerate & emphasize key skills & knowledge
2. Develop curricula, supporting materials & real-time resource
3. Leverage adult learning principles to facilitate retention
4. Identify the target workforce
5. Strategically coordinate training to ensure that staff are ready for deployment whenever they are needed

## Implementation



Thursday, April 2, 2020

## Early Site-specific MSHS COVID-19 Forecast



Source: <https://docs.google.com/document/d/17VF6TOh9L5H3Tlg1D48XaifYAulse1k8bU6t5klOFY/edit>

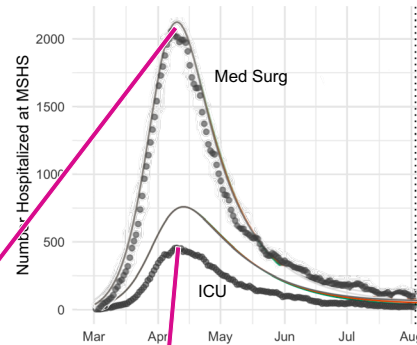
Beth Percha (SIR epidemic models) bethany.percha@mssm.edu, Allan Just (length of stay estimates) allan.just@mssm.edu, Nick DeFelice (SEIR epidemic models) nicholas.defelice@mssm.edu, Data from Paul Francaviglia & the Epic team



Monday, April 6, 2020

## Dodged a Bullet??

- ▶ While we did not exceed our baseline Med-Surg capacity, we overwhelmed our incumbent LIPs . . .
- ▶ EDs were overrun
- ▶ All surgical beds were filled with medicine patients
- ▶ ICU volume was roughly twice baseline at the peak



Med Surg Capacity

	Pre-COVID M/S Beds	Incremental Surge Beds	Total Beds at Surge	% Increase
MSH	845	383	1228	45%
MSM	242	59	301	24%
MSW	223	97	320	43%
MSBI	140	286	426	204%
MSQ	135	22	157	16%
MSB	197	0	197	0%
MSSN	266	183	449	69%
<b>System</b>	<b>2048</b>	<b>1030</b>	<b>3078</b>	<b>50%</b>

ICU Capacity

	Pre-COVID ICU Beds	Incremental Surge Beds	Total Beds at Surge	% Increase
MSH	94	140	234	149%
MSM	50	50	100	100%
MSW	31	28	61	85%
MSBI	13	86	104	478%
MSQ	8	25	33	313%
MSB	12	15	27	125%
MSSN	78	96	124	343%
<b>System</b>	<b>243</b>	<b>440</b>	<b>683</b>	<b>181%</b>

## Conglomeration of Practitioner Resources

Physicians	Credentialed	Deployed
Allergy & Immunology	1	0
Anesthesiology	45	28
Cardiology	4	3
Critical Care	60	38
Dermatology	1	0
Emergency Medicine	26	16
Family Medicine	30	24
Geriatrics	2	0
Hematology / Oncology	1	1
Hepatology	1	0
Infectious Diseases	9	6
Internal Medicine	53	32
Palliative Care	12	1
Pediatrics	5	1
Preventative Medicine	1	0
Psychiatry	3	2
OB/GYN	5	2
Surgery	5	3
<b>Total Physicians</b>	<b>264</b>	<b>157</b>

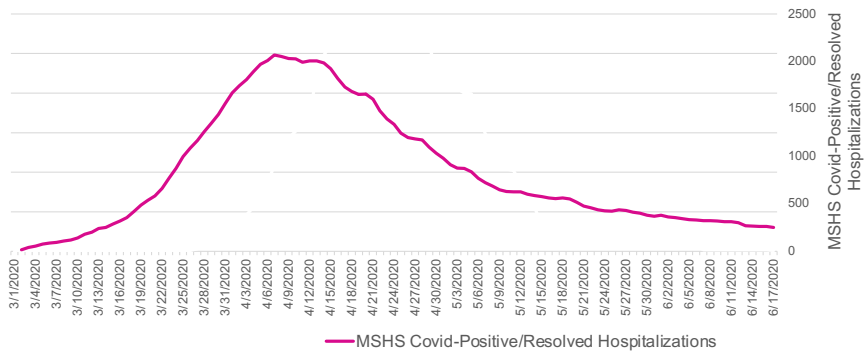
Advanced Practice	Credentialed	Deployed
CRNA	172	121
Nurse Practitioner	74	50
Physician Assistant	79	41
<b>Total APPs</b>	<b>325</b>	<b>212</b>

	Credentialed	Deployed
<b>Total External LIPs</b>	<b>589</b>	<b>369</b>

- Volunteers
- Individual per diem practitioners
- Locum tenens agencies
- Contracted practitioner groups
- Relief organizations
- Total solution firms

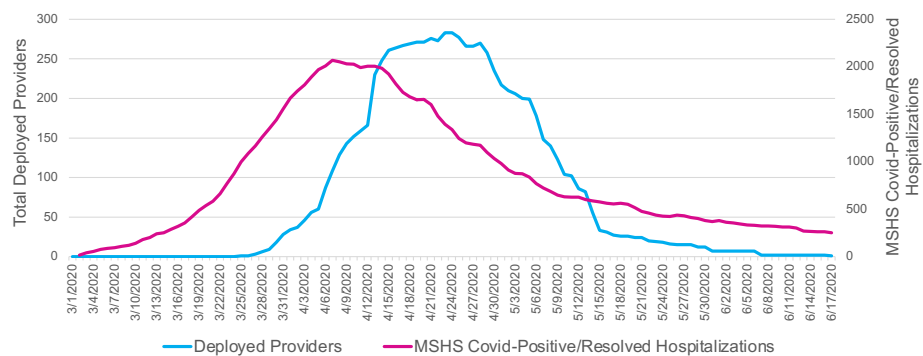
## Mismatch Between Patients & Providers

COVID-19 Hospitalizations



## Mismatch Between Patients & Providers

COVID-19 Hospitalizations & Deployed Providers



## Scarce Resource Allocation



NEWS

### Which coronavirus patients will get life-saving ventilators? Guidelines show how hospitals in NYC, US will decide

Kevin McCoy and Dennis Wagner USA TODAY  
Published 7:00 a.m. ET Apr. 4, 2020 | Updated 2:17 p.m. ET Apr. 4, 2020

### The world is scrambling to buy ventilators in the Covid-19 pandemic. One country has only four of them -- for 12 million people

By Amy Woodyatt, CNN  
Updated 1:29 PM ET, Sat April 18, 2020

CBS THIS MORNING

Politics & 2020 Fo

CBS NEWS April 11, 2020, 1:04 PM

Ventilator shortage spurs team of doctors to take extreme measures

### Selected Triggers:

- Volume of ventilator & high-flow nasal cannula (HFNC) use
- Respiratory therapist shortage
- Medication shortages
- Remaining supply levels (e.g., filters, tubing, etc.)

### MSHS PM Ventilator Update

3/30/2020

Device Type	Out for Service	Rental Ordered	Purchase Ordered	Rental Arrived	Owned	Total OnHand	3/30/2020 Available Today	Utilization Today
Ventilator	266	59	816	38	815	587	194	67.0%
MSB	40			5	80	45	3	93.3%
MSBI	41				71	30	5	83.3%
MSH	78				257	179	32	82.1%
MSM	31			20	108	97	49	49.5%
MSQ	41				71	30	15	50.0%
MSSN				3	87	90	38	57.8%
MSW	35			7	110	82	52	36.6%
Warehouse		59	816	3	31	34		1
Transport Vents		10	101	0	51	51	39	23.5%
Specialty Vents-Anesthesia		0	0	0	233	233	226	3.0%
Specialty Vents	15	0	0	70	73	128	98	23.4%
HFNC		10	35	5	103	108	41	62.0%
BiPAP/CPAP	22	12	100	25	374	377	255	32.4%
Grand Total	303	91	1052	138	1649	1484	853	42.5%

### Prepare

- Develop protocol for sharing 1 ventilator between 2 patients

### Conserve

- Amend policy, decreasing frequency of ventilator circuit & filter changes

### Substitute

- Provide virtual respiratory therapy (RT) support through TeleRT coordinated by the Clinical Command Center

### Adapt

- 24/7 Palliative Care hotline

### Re-allocate

- Move ventilators around the Health System

## Clinical Triage Team

### Key Principles

- Guidance from NY State, peer institutions & the literature
- Multi-disciplinary stakeholder group (Nursing, Emergency Medicine, Internal Medicine, Critical Care, Palliative Care, Anesthesiology, Respiratory Therapy, Legal Affairs, Ethics)
- BUT failed to include our Office for Diversity & Inclusion
- Equity & fairness
- Decrease moral burden & provide support

### Operations

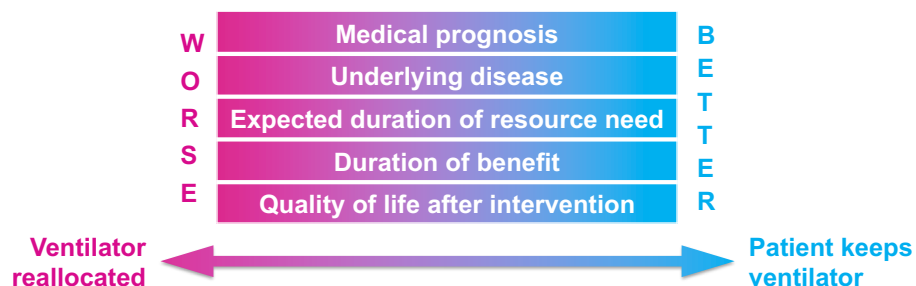
- Clinical Command Center
- Leverage IT & Emergency Management structures
- Establish 24/7 on-call team

## Clinical Triage Team

Overarching goal ➡

Allocate resources to those likeliest to benefit

### Key Considerations



Hick JL, Robinson L, O'Laughlin DT, Farmer JC.  
Clinical review: Allocating ventilators during large-scale disasters – problems, planning, and process  
Crit Care. 2007; 11(3): 217. Published online 2007 Jun 19. doi: 10.1186/cc5929



## Summary

- ▶ Despite early awareness of the looming pandemic, we got off to a slow start
- ▶ The volume impact was inconceivable at the outset
- ▶ Ramping up LIP staffing operations was heroic
- ▶ Accurate planning for staffing needs was impossible
- ▶ The cost was staggering
- ▶ Scarce resource allocation was generally well-thought through
- ▶ Thankfully, we have yet to be pushed to binary rationing

29

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212-659-9226

# Health Care Workforce Well-Being in the Wake of COVID-19: *The Mount Sinai Experience*

**Jonathan Ripp, MD, MPH**

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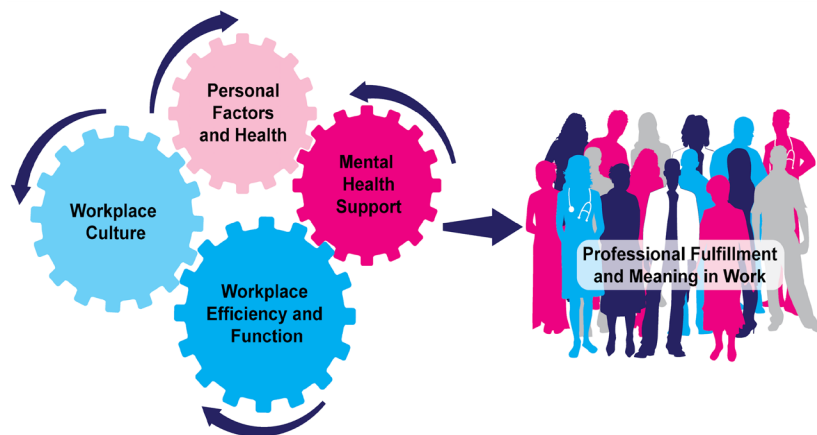
## Objectives

1. Consider how the COVID-19 pandemic impacted the emotional well-being of the healthcare workforce in NYC
2. Identify changes needed to physician well-being initiatives in the context of the COVID-19 “new normal”
3. Make the case for continuing to prioritize physician well-being in the present circumstances
4. Be familiar with the resources available to address these stressors and well-being needs

## Icahn School of Medicine at Mount Sinai

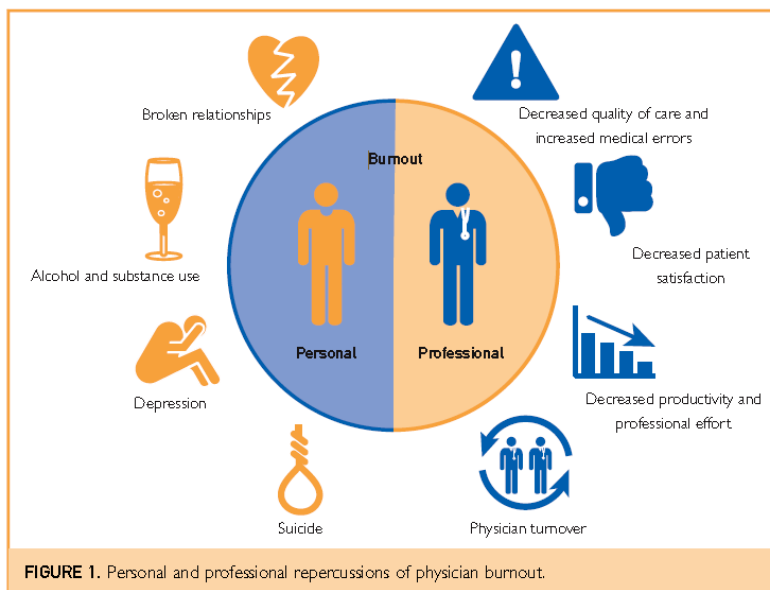
### Office of Well-Being and Resilience

#### Model of Healthcare Worker Well-Being



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## Consequences of Job Burnout



Shanafelt et al. Mayo Clin Proc. 2016

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## The Pandemic Curve and Associated Stressors

### Greatest Stressors

#### 1) Fear for Basic Needs

- When/what will I eat?
- How will I be kept safe and keep others safe?
- Who will care for my children?
- How will I get to and from work?

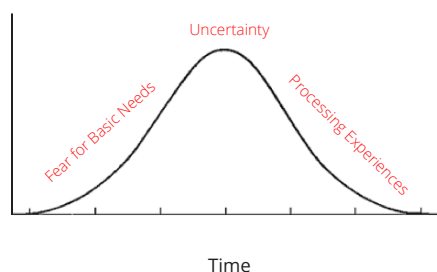
#### 2) Uncertainty

- How long will this workload continue?
- Will I be able to do the job if redeployed?
- Am I doing enough?
- Will I be supported by my employer?
- Will I be able to make the difficult decisions?

#### 3) Processing Experiences

- Grief and loss
- PTSD or PT Growth
- Catching my breath and time to reflect
- The overlay of societal upheaval and attention to racial injustice

Number of  
Cases



Shanafelt et al. JAMA. 2020; Ripp et al. Academic Medicine. 2020

## The Pandemic Curve and Associated Stressors

### Strategies to Address

#### 1) Provide Basic Daily Resources

- Food (free and subsidized)
- PPE Clarity
- Childcare resource
- Transportation and Parking

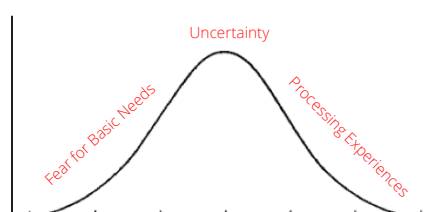
#### 2) Communication

- Weekly wellness messages
- Town Halls
- Transparency

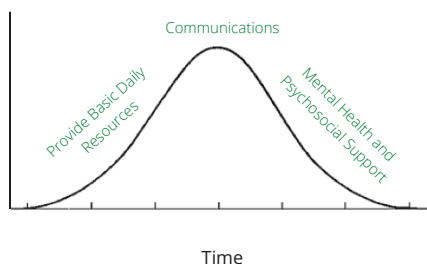
#### 3) Psychosocial & Mental Health

- Support Groups
- Phone Lines
- Telepsychiatry
- Mental Health "PPE"
- Frontline Relief

Number of  
Cases



Number of  
Cases



Shanafelt et al. JAMA. 2020; Ripp et al. Academic Medicine. 2020

Viewpoint

ONLINE FIRST FREE

April 7, 2020

# Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic

Tait Shanafelt, MD<sup>1</sup>; Jonathan Ripp, MD, MPH<sup>2</sup>; Mickey Trockel, MD, PhD<sup>3</sup>

► Author Affiliations | Article Information

JAMA. Published online April 7, 2020. doi:10.1001/jama.2020.5893

Request	Principal desire	Concerns	Key components of response
Hear me	Listen to and act on health care professionals' expert perspective and frontline experience and understand and address their concerns to the extent that organizations and leaders are able	Uncertainty whether leaders recognize the most pressing concerns of frontline health care professionals and whether local physician expertise regarding infection control, critical care, emergency medicine, and mental health is being appropriately harnessed to develop organization-specific responses	Create an array of input and feedback channels (listening groups, email suggestion box, town halls, leaders visiting hospital units) and make certain that the voice of health care professionals is part of the decision-making process
Protect me	Reduce the risk of health care professionals acquiring the infection and/or being a portal of transmission to family members	Concern about access to appropriate personal protective equipment, taking home infection to family members, and not having rapid access to testing through occupational health if needed	Provide adequate personal protective equipment, rapid access to occupational health with efficient evaluation and testing if symptoms warrant, information and resources to avoid taking the infection home to family members, and accommodation to health care professionals at high risk because of age or health conditions
Prepare me	Provide the training and support that allows provision of high-quality care to patients	Concern about not being able to provide competent nursing/medical care if deployed to new area (eg, all nurses will have to be intensive care unit nurses) and about rapidly changing information/communication challenges	Provide rapid training to support a basic, critical knowledge base and appropriate backup and access to experts
Support me	Provide support that acknowledges human limitations in a time of extreme work hours, uncertainty, and intense exposure to critically ill patients	Need for support for personal and family needs as work hours and demands increase and schools and daycare closures occur	Clear and unambiguous communication must acknowledge that everyone is experiencing novel challenges and decisions, everyone needs to rely on each other in this time, individuals should ask for help when they need it, no one needs to make difficult decisions alone, and we are all in this together
Care for me	Provide holistic support for the individual and their family should they need to be quarantined	Uncertainty that the organization will support/take care of personal or family needs if the health care professional develops infection	Provide support for physical needs, including access to healthy meals and hydration while working, lodging for individuals on rapid-cycle shifts who do not live in close proximity to the hospital, transportation assistance for sleep-deprived workers, and assistance with other tasks, and provide support for childcare needs
			Provide support for emotional and psychologic needs for all, including psychologic first aid deployed via webinars and delivered directly to each unit (topics may include dealing with anxiety and insomnia, practicing self-care, supporting each other, and support for moral distress), and provide individual support for those with greater distress
			Provide lodging support for individuals living apart from their families, support for tangible needs (eg, food, childcare), check-ins and emotional support, and paid time off if quarantine is necessary

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## ACADEMIC MEDICINE

Wolters Kluwer Health

Acad Med. 2020 Apr 21 : 10.1097/ACM.0000000000003414.

PMCID: PMC7176260

Published online 2020 Apr 10. doi: 10.1097/ACM.0000000000003414

PMID: 32282344

### Attending to the Emotional Well-Being of the Health Care Workforce in a New York City Health System During the COVID-19 Pandemic

Jonathan Ripp, MD, MPH<sup>1</sup>; Lauren Pecorello, MD, MPH,<sup>2</sup> and Dennis Charney, MD<sup>3</sup>



Shapiro DE, Duquette C, Abbott LM, Babineau T, Pearl A, Haidet P. Beyond Burnout: A Physician Wellness Hierarchy. Designed to Prioritize Interventions at the Systems Level. Am J Med. 2019

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## Well-Being Staff Resources During COVID-19

The well-being of our faculty and staff is critical to help us meet the challenge of COVID-19. Find the resources you need—from basic needs like childcare and food, to your mental health and spiritual needs.

For help or guidance in navigating any of the Well-Being Resources, including information on basic needs, general psychosocial support for you and your family, referrals to the appropriate mental health treatment services, and more, please call the **Resource Navigation Phone Line** at [REDACTED]. The line is open and staffed 7am-8pm.

- [Basic Needs & Self-Care During COVID-19 for Staff](#)
- [Mental Health & Psychosocial Support During COVID-19](#)
- [On the Ground Support for Frontline Workers](#)

### COVID-19 Staff Resources

- Employee Health
- Well-Being Staff Resources
  - Basic Needs & Self-Care
  - Mental Health and Psychosocial Support
  - On the Ground Support for Frontline Workers
- Frequently Asked Questions
- Clinical Guidelines and Information for Staff
- Personal Protective Equipment (PPE) Directory and Guidelines
- Faculty and Staff Education During COVID-19
- General COVID-19 Non-Clinical Policies
- HR Information
- Talent Development and Learning
- Patient Materials to Use
- Staff Emails & Town Halls
- Register to Help
- Information on COVID-19 for Researchers

<https://www.mountsinai.org/about/covid19/staff-resources/well-being>

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## Basic Needs & Self-Care

It is imperative that during this crisis the basic needs of our heroic workers are being met. This page outlines some of the ongoing efforts to address your basic needs as we fight this pandemic together. We have included resources for nourishment, child and eldercare, transportation, accommodations and personal safety. Feel free to continue to check back as the page is updated.

For help finding and identifying the right resource for you, please call the dedicated **Resource Navigation Phone Line** at [REDACTED]. The line is open and staffed 7am-8pm.

- Food Provisions
- Transportation & Parking
- Housing Accommodations
- Family Resources
- Self Care & Stress Management
- Fitness & Nutrition
- Personal/Family Safety & Medical Care

## Mental Health and Psychosocial Support

During this time of heightened emotions, it is normal to need support. We encourage you to seek mental health evaluation and/or treatment or check in with yourself, and connect with others via a wide array of group discussions, individual support, and extensive spiritual care offerings. Remember: We are in this together.

For more general information regarding your mental health during this time, please see this [Mental Health Guide](#), created by Craig Katz, MD, Clinical Professor of Psychiatry and Director of Mount Sinai's Program in Global Mental Health.

For help finding and identifying the right resource for you, please call the dedicated **Resource Navigation Phone Line** [REDACTED]. The line is open and staffed 7am-8pm.

- Crisis Support
- One-on-One Support
- Facilitated Group Discussions
- Spiritual Care & Peer Support
- Well-Being Tips and Coping Strategies
- Additional Resources

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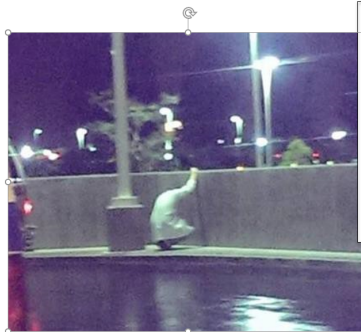


## Mount Sinai Frontline Relief Program Snack Stations & Well-Being Centers

- ▶ Interactive recharge rooms
  - immersive spaces with music, scent, meditative visual elements, lighting and sound
- ▶ Nourishment and rest areas
- ▶ Facility Dog Visits



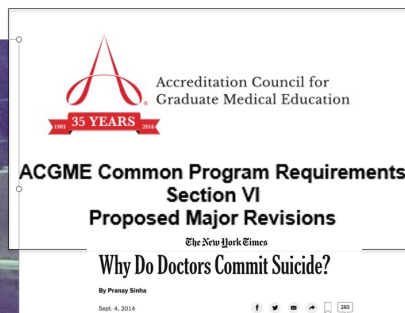
## Making the Case for Well-Being – Pre-COVID



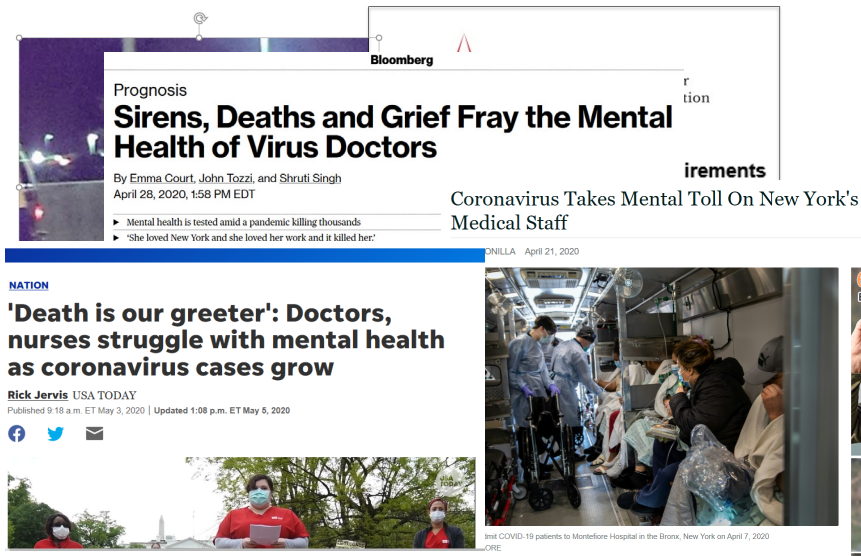
Special Communication | Physician Work Environment and Well-Being  
December 2017

### The Business Case for Investing in Physician Well-being

Tait Shanafelt, MD<sup>1</sup>; Joel Goh, PhD<sup>2,3</sup>; Christine Sinsky, MD<sup>4</sup>



## Making the Case for Well-Being – In the COVID-19 Era



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## Lessons Learned and Next Steps

- ▶ The approach to clinician well-being almost certainly requires a pivot in light of the pandemic
  - Shifting Needs and Drivers of Well-Being may lead to shifting priorities as well as consideration of societal level factors
  - Trauma and Moral Distress will likely lead to significant long-term consequences
- ▶ Unpublished Data from our Frontline Health Care Workers sent to >6000 show large burden of PTSD, MDD and Anxiety Symptoms
- ▶ Where to from here?
  - Everyone needs support, some will need treatment
  - There are lots of resources to help for support
  - Regular, authentic, transparent and supportive communications can't be overemphasized
  - Announcing our new Center for Stress, Resilience and Personal Growth

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Thank you for attending "Second Annual Best Practices Conference: Reconsidering Health Care in the Era of Pandemics," provided by Icahn School of Medicine at Mount Sinai and Healthfirst.

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## ABOUT HEALTHFIRST

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For more information on Healthfirst, visit [healthfirst.org](https://healthfirst.org).





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