Family Doctor

A Journal of the New York State Academy of Family Physicians

Summer 2021

Volume ten, Number one

Focus:
COVID-19

New York State Academy of Family Physicians

FEATURE ARTICLES:

- Overcoming Barriers to COVID-19 Vaccination for People with Developmental Disabilities
- Reproductive Health Care in the Time of COVID: Changes We Can Take with Us
- An Aggressive Approach to Outpatient COVID-19 Management with System Wide Benefits in Relation to Hospitalization and Death
- Geriatric Grief Management in the COVID-19 Pandemic: Barriers and Best Practices
- Communicating with COVID-Vaccine Hesitant Patients
- Pandemic Teaching: What we have Gained and Lost

The Winter Weekend planning committee team, Drs. Heather Paladine (committee chair), Steve Hoag, Phil Kaplan, Suganya Mahinthan, Myranda Steingraeber, Wayne Strouse, Becky Williams, Romulo Vasquez and Jocelyn Young, invites you to attend an in-person, live conference!

Miss seeing your colleagues? Join us at Winter Weekend, January 14-16 in Saratoga Springs. The conference will offer approximately 16 Live Credits and will include workshops and interactive sessions.

Visit www.nysafp.org for up-to-date information and registration.

Topics include (but not limited to):

- Patient Centered Contraceptive Care
- Bipolar Disorder--More Common Than You Think, and You Can Do Something About It
- Musculoskeletal Exam Workshop
- Integrative Approaches to Headache Management in the Primary Care Setting
- Childhood Mental Health
- Up-to-date COVID Vaccine Information
- Controlled Substance Safety Group Workshop
- Vaccination Self-Assessment by AFIX
- The Numbers Needed to Treat: Cases and Exercises in Quantitative Reasoning
- Transgender Care
- Student Hands-on Workshop
- Research Poster Session

For additional information on Winter Weekend contact Kelly Madden, Director of Education at 518-489-8945 or kelly@nysafp.org

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From the Executive Vice President

By Vito Grasso, MPA, CAE

I am a proud father of daughters. I have learned much about disparities in opportunity which women have endured as a result of raising my daughters, caring for them and sharing their struggles with the social, educational and employment situations they have encountered. I believe I understand what it takes for women to succeed in our society, and I appreciate the unique and special qualities which successful women possess.

I would like, therefore, to use my column to comment briefly about two other women whom I respect and admire who have made significant contributions to the Academy, and are now candidates for AAFP office and deserve our recognition and support.

Drs. Tochi Iroku-Malize and Sarah Nosal are both past presidents of NYSAFP. They are women of substance, character and competence and they have each contributed immeasurably to the growth and enhancement of our chapter. Their energy and passion are palpable. Their presence among our leadership has energized and motivated our board, our Congress and our commissions in ways that only people who have overcome obstacles can contribute. We are better as an organization because they have persevered, have achieved in their careers and have brought the determination and eloquence of example to our deliberations at every level of our governance. I am confident and hopeful that they will have the same impact upon the AAFP.

Qualities of leadership are important. Tochi and Sarah have been tested and have demonstrated that they are clearly leaders who can be counted on. The members they are competing with for AAFP office are also accomplished leaders. It is a blessing for this organization to have so many successful and committed members to choose from. Leadership alone is not enough to take the Academy forward and to provide the insight and perspective necessary to frame positions on important policy matters, to develop programs and systems of support for members as we confront the significant changes ahead in medicine and healthcare, and to represent the changing face of family medicine.

The New York chapter is a diverse and active chapter. We have consistently been a leader among chapters in moving the agenda of the AAFP forward through our introduction of thoughtful resolutions on important and emerging issues of national significance. Our leadership in areas including women's health, climate change, environmental protection, reform of our healthcare system and equity and social justice has stimulated and even provoked debate within the AAFP Congress of Delegates. Tochi and Sarah have authored many of our most important resolutions in these areas and, as members of our delegation to the COD, have eloquently and forcefully defended them in debate.

Debate at the COD is often characterized by a clash of values. Firmly held views reflecting social, political, religious, geographic and gender bias are just as common within the Academy as they are in society generally. In the course of my 27 years with the Academy I have witnessed the slow but steady evolution of the COD as more women and people of color have populated the floor of the Congress. The quality and nature of debate has remained dignified and intelligent, but the experiences of delegates with histories of disenfranchisement have added perspective which has enriched discourse and produced fundamental change in priorities.

As we emerge from the horrific experience of the COVID pandemic and confront a traumatized world which has changed and will continue to change, we need leaders who have the courage, perspective and will to confront those challenges. Tochi and Sarah have the experience, the skills and the determination to meet the challenges which are ahead. As leaders who have overcome challenges, they have demonstrated the capacity to embrace and facilitate change and to lead people, as Rosalyn Carter has said, "… where they don't necessarily want to go, but ought to be."

Tochi and Sarah have been tested and have demonstrated that they are clearly leaders who can be counted on

Congratulations James Mumford, MD, FAAFP

75th President, New York State Academy of Family Physicians

President's Post

By James Mumford, MD, FAAFP

Congratulations and Thank you to 2021-2022 NYSAFP Board of Directors

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"As an organization, powered by the strength of individuals, our New York State Academy will continue to evolve, to assist and advocate for us, and to push us towards our growing edge. I look forward to the year ahead; representing you, the Academy, and our patients both virtually and literally as we move towards a new and better version of normal"
– Excerpted from the 2021 Congress of Delegates Program, May 2021

"There is nothing that can't be questioned, challenged or changed"
– James Mumford

Albany Report

By Reid, McNally & Savage

2021 Session Recap

The New York State Legislature adjourned the 2021 session with the Senate gaveling out at 9:30 PM on June 10th, and the Assembly following suit at 4 AM on July 11th. Legislators passed nearly 900 individual bills during the approximately six-month session. Upon adjourning, both houses signaled a possibility of a return this year with unfinished business pending a push by progressive members to seal more criminal records and Governor's Cuomo's proposal to change the leadership structure of the MTA.

Overall, the session was a successful one for NYSAFP and its priorities. NYSAFP achieved positive outcomes for all state budget priorities this year. We have outlined these successes below.

Final State Budget Achievements

- $9 million in full funding for **Doctors Across NY**; Proposed cut rejected
- $2.2 million in restored funding for **Area Health Education Centers (AHEC)**; State funding for AHEC had been eliminated last year
- Restoration of $600 million in proposed **Medicaid service** and provider cuts
- $102 million for the **Physician Excess Malpractice Program**; Rejecting over $50 million in a proposed cut that would have been passed down as a tax on physicians in the program
- Protection of **Physician Due Process Rights** with Office for Professional Medical Conduct (OPMC) proceedings; Rejection of proposal to allow NYSDOH to make OPMC complaints public
- Enactment of **Telehealth Flexibilities** to recognize the provision of telehealth anywhere in the United State for delivery and payment purposes, with patient location as the originating site
- A one-year extension of the current **Nurse Practitioner Collaborative Agreement** law, with rejection of a proposed six- year extension, and rejection of efforts to expand the law to remove current collaboration requirements

Problematic Bills Defeated

On the legislative front, NYSAFP worked closely with others in organized medicine to defeat a number of problematic bills as outlined below.

Independent Practice of Nurse Practitioners (S3056 Rivera/A1535 Gottfried)-Defeated

This bill would have removed remaining collaborative relationship requirements in law. It was moved to the floor in the Senate but was never voted on by that house. It was moved back to the Senate Rules Committee. In the Assembly the bill was referenced to the Higher Education Committee and was not scheduled for a vote.

Patient Medical Debt (S2521-B Rivera/A3470-B Gottfried)-Defeated

Very late in the session this bill was amended to eliminate every provision (including the prohibition on billing patients for providers with a contractual relationship with a hospital) except for language pertaining to facility fees. The amended bill provides that no hospital or health care provider may bill or seek payment from a patient for a facility fee that is not covered by the patient's health insurance carrier unless the patient was notified prior to the date of service that a facility fee would be applicable. In no event can a facility fee be charged for services related to the provision of preventive care services as defined by the United States Preventive Services Task Force. While the bill passed the Senate, it remained in the Assembly Ways and Committee when session ended.

Wrongful Death (A6770 Weinstein/S74-A Hoylman)-Defeated

This bill would enable the families of loved ones who experienced "wrongful death" to recover compensation for their emotional anguish. It was not passed by either house and remained in the Senate Finance and Assembly Rules Committee.

Bills of Interest Passed by Both Houses

Both houses passed a number of bills supported, influenced or monitored by NYSAFP this session. We've included some highlights below. Most have not been transmitted to or acted by the Governor yet but we do note where executive action has been taken.

Midyear Formulary Changes (S4111 Breslin/A4668 Peoples-Stokes)

This bill supported by NYSAFP and other patient and provider organizations prohibits health insurers/pharmacy benefit managers (PBMs) from making midyear drug formulary changes to maintain continuity in coverage for those prescription drugs during the course of the enrollment year. The bill also requires insurers to provide adequate notice of the intent to remove a prescription on the upcoming plan year.

Marijuana Legalization (S854A Krueger/ A1248A Peoples-Stokes)

As noted in prior updates, on March 31st this bill was signed into law (Chapter 92 of the laws of 2021) to legalize adult use cannabis and establish a new Office of Cannabis Management for the regulation of cannabis in New York. NYSAFP has formed a committee to develop the Academy's comments and recommendations to influence the implementation process for the new law.

Pelvic Exams (S210B Persaud/ A5489B Solages)

Legislation had been introduced to require physicians and other providers giving first pelvic exams to provide a pamphlet to patients in advance about the examination. NYSAFP worked closely with ACOG, MSSNY and the bill sponsors to change the bill to support the development of such educational materials by the State Department of Health in consultation with associations representing family physicians, OB/GYN and others but to remove the mandate that it is provided to patients. In response, the bill was amended and no longer mandates its use, rather it would be an available resource that physicians and other providers may choose to refer patients to.

Establishes an Opioid Settlement Fund (A6395B Woerner/S7194 Rivera)

This bill requires all funds received by the state as the result of a settlement or a judgment in litigation against opioid manufacturers, distributors, dispensers, consultants or resellers to be deposited into the opioid settlement fund, and that such funds shall not supplant or replace existing state funding for SUD programs.

Medication Assisted Treatment (S649-A Harckham/A2030 Rosenthal L)

This bill would allow individuals under Medicaid the ability to access whichever MAT medication is most beneficial to them and their needs, without utilization control, mandated prior authorization, or lifetime limits.

Expansion of Opioid Prevention Program (S6571 Hinchey/A6166A Rosenthal L.)

This bill expands the current Opioid Prevention Program to require the Department of Health to also publish findings and information on alcohol overdose data, including emergency room utilization and other information on a quarterly basis. The bill requires all such data to be posted on the Office of Addiction Services and Supports website.

Establishes a 9-8-8 Suicide Prevention and Mental Health Crisis Hotline System (A7177B Gunther/ S6194B Brouk)

This bill establishes a three-digit, 9-8-8 suicide prevention and mental health crisis hotline system that will save lives by connecting people experiencing mental health crisis with compassionate, lifesaving, and culturally competent mental health care services.

continued on page 10

continued from page 9

G6PD Deficiency and ALD Screening for Newborns (S4316 – Gustavo/A4572 – Gottfried)

This bill amends Public Health Law § 2500-a to add glucose-6-phosphate dehydrogenase deficiency to the list of conditions that all newborns are screened for. This section also includes technical cleanup to make the section clearer and format it in line with the rest of the Public Health Law. Clarifies that adrenoleukodystrophy is also added to the screening list.

Improved Access for Schools to the Statewide Immunization Database (A5062 Kelles/ S4962 Reichlin-Melnick)

This bill expands the permitted access by schools to the Statewide Immunization Registry to enable batch data downloads for children attending their school.

Child Poverty Reduction Advisory Council (S2755C Ramos/ A1160-C Bronson)

This bill would establish the Child Poverty Reduction Advisory Council, chaired by a representative of the Executive Chamber and the Commissioner of the Office of Temporary and Disability Assistance (OTDA) and with two appointees each from the Senate, Assembly, and OTDA. The Governor is responsible for additional appointees from various agencies, non-profits focused on poverty, and individuals affected by poverty. The council shall explore expanding specific policies, making new recommendations, and will publish benchmarks, timelines, and reports to make sure that New York State meets the goal of reducing child poverty by 50% in a decade.

Lyme Disease and Other Tick-Borne Disease Awareness (S4089 Hinchey/A6888 Barrett)

This bill amends Agriculture and Markets Law to establish a public awareness campaign regarding Lyme disease and other tick-borne diseases. The campaign will seek to educate farmers, farmworkers, and others regarding Lyme diseases and other tick-borne diseases, recognition of symptoms, available treatments, and preventive measures.

Antimicrobial Resistance Prevention and Education Program (S5847 Woerner/S2191 Kavanagh)

This bill requires hospitals and nursing homes to establish an antimicrobial stewardship program that meets or exceeds federal Medicare and Medicaid standards. The program must include an ongoing process to measure the impact of the program, at least annually. Facilities must establish and implement training regarding infection prevention and control.

Regulation of Pharmacy Benefit Managers (A1396 Gottfried/ S3762 Breslin)

This bill requires licensure for pharmacy benefit managers (PBMs) and specifies their duties and obligations as service providers and oversight by the Department of Financial Services and State Health Department.

Medicaid Pharmacy Services (A7598 Gottfried/ S6603 Skoufis)

This bill would prohibit restrictive pharmacy networks in Medicaid Managed Care and allow patient choice in how their prescriptions are provided including authorizing delivery by a local pharmacy.

Single Payer Bill Remains in Committee

Legislation (S5474 Rivera/A6058 Gottfried) strongly supported by NYSAFP to establish a single payer health system in NY with authorization for collective bargaining by physicians, remained in the Senate Health Committee and Assembly Codes Committee when the session ended. The legislation does have a majority of the Democratic members in each house on the bill as cosponsors, a testament to the years of advocacy by NYSAFP and partners building support. However, due to the objections by unions on the impact of this bill on their health benefits, as well as pushback on the cost impacts to the State of the legislation it was not moved by either house this session.

NYSAFP Campaign for Universal Reporting to Vaccine Registry

Throughout the session, NYSAFP championed legislation (S75A Hoylman/ A279A Gottfried) for universal reporting of adult vaccines to the statewide or NYC registries unless a patient requests that the record not be reported. NYSAFP built a coalition of supporters including other providers like MSSNY, internists, nurses, and pharmacists as well as public health organizations like the American Cancer Society, public health association and county health officials and groups focused on health equity including the NAACP. Due to the strong advocacy effort, the bill gained a number of cosponsors in each house and progressed to the Senate Floor and Assembly Rules Committee (last stop before the Assembly Floor). Unfortunately, the bill was not advanced further before the session ended but made its greatest progress since introduction three years ago. NYSAFP will continue to educate and advocate on the importance of this public health measure leading into the next session.

We would very much like to thank NYSAFP leadership and the full membership for all of your support and advocacy this session. This includes answering NYSAFP's calls to participate in the March 1st virtual lobby day, multiple grassroots activities, and other legislative and media outreach in support of NYSAFP's agenda. We wish you an enjoyable summer and look forward to continued work on the priorities of import to family physicians and those you serve.

For additional resources of interest:

Here is Reid, McNally & Savage's sector-by-sector summary of all health/mental hygiene related legislation that passed both houses this session. Most await action the Governor.

Additionally, below is a link for further information on the provisions of the final FY 2021-22 State Health Budget, the Reid, McNally & Savage SFY 2021-22 Final Budget Health/Mental Hygiene Summary can be found here.

For access to links in our printed journal, contact penny@nysafp.org.

Communicating with COVID-Vaccine Hesitant Patients

By Francesca Decker, MD, MPH

Introduction

Vaccine hesitancy has been an ongoing issue for family doctors and our patients, but it has reached a renewed urgency in the setting of COVID-19 and heightened levels of disinformation and misinformation interwoven with political polarization.[1,2,3,4] This may lead some clinicians to dread talking to their patients about the topic. However, research has shown consistently that individuals' own doctors or health care providers are the number one most trusted source of information about vaccines, and the COVID-19 vaccine is no exception, with 79% of respondents in one survey saying they would trust their doctor or health care provider when deciding whether to get the vaccine.[2,3,4] This was true across age, race and political affiliation.[4]

Approved vaccines for adults in the United States include the mRNA vaccines from Pfizer and Moderna, and the adenovector vaccine from Johnson and Johnson. Pfizer's vaccine has recently received Emergency Use Authorization from the FDA for use in children from age 12-15.[5] In New York State in June, the rates of hesitancy varied from roughly 5-9%, with lowest rates in more urban, liberal counties, and highest rates of hesitancy in the North Country counties along the Canadian border.[6] The good news is that as of June 15, 70% of all New Yorkers had received one dose of their COVID vaccine, with 51% of the state population having completed their vaccine series, and 63% of those aged 18 and up.[7] Still, issues of access do continue to be a barrier for some patients, and 34% of Americans continued to have some degree of vaccine hesitancy as of May (exacerbated by the Johnson and Johnson vaccine pause), with 13% of Americans saying they absolutely will not get the vaccine, a number that has been fairly steady since December.[8] But it's clear that across groups, patients' personal physicians are a highly trusted source, so it is essential that family doctors have these difficult conversations over the coming weeks and months.

Strategies for Communication

Previous research and recommendations on communicating about vaccine hesitancy,[1,2,3] as well as more recent publications regarding COVID-related behaviors specifically,[9,10] offer useful strategies for effective communication about vaccines.

1. **Take a breath** – While physicians may feel apprehensive about initiating vaccine conversations, there is good evidence that they are effective. Many patients just have questions and are concerned about the wellbeing of themselves and/or their children, seeking clarification and reassurance.[2] Asking questions does not mean they won't accept the vaccine. As Dr. Jamie Loehr, an Ithaca community doctor and former AAFP Vaccine Fellow, writes: the first step in a vaccine encounter is to "Take Your Own Pulse."[1]
2. **Start the conversation with an open mind** – Clinicians should suspend judgment and approach the discussion with curiosity.[1,10] Patients may also be apprehensive about discussing the COVID-vaccine, anticipating judgment. Clinicians are encouraged to listen, without shaming.[11] As a Harvard cardiologist puts it, "Before you attempt to persuade, try to understand."[10]
3. **Give a strong recommendation** – But use judgment with each patient. There is evidence that "presumptive" communication is more effective than participatory communication at getting parents to get their kids immunized.[1,2,3] "I'm going to schedule you for your vaccine," or "You're due for your vaccine today" has previously been shown to be more effective at getting parental vaccine acceptance than "Would you like this vaccine?" However, this type of communication can also lower patient ratings of visit quality, and given the politicization of the COVID vaccine, it may alienate some patients.[3,10,11] Family doctors know our patients best, but whether taking a presumptive or participatory approach, use language strongly recommending the vaccine. A physician's recommendation has been shown to be the most important reason patients accept a vaccine.[1]
4. **Acknowledge concerns** – Vaccine hesitancy has historically been due to the three C's: a lack of Confidence in vaccine safety, efficacy or in science or health profession/professionals, Complacency (belief that a disease is not that serious) and Convenience (access, opportunity).[1,2] This is still true with COVID.[12] Many clinicians were also hesitant when the vaccines first rolled out, and it may be helpful to acknowledge this and then segue into a discussion of what led to ultimately getting vaccinated, if the clinician has now done so.[10,11,13]
5. **Educate yourself** – This includes information about safety, misinformation, philosophical and religious concerns.[2] For example, there have been religious concerns about the use of aborted fetal cells in the development of the these vaccines, so it may be useful to reference relevant religious leaders who have stated permission to use the COVID-19 vaccine, along with the religious responsibility to care for one's community.[14,15,16,17] It may also be useful for clinicians to understand the Emergency Use Authorization process, and the history of the mRNA vaccine research process. Additionally, in May, the CDC published a robust overview of studies supporting their guidelines for vaccinated people not wearing

continued on page 12

continued from page 11

masks, and the safety and efficacy trials of all three vaccines have now been published in the New England Journal of Medicine (See Table 1).[18,19,20,21, 22,23,24,25,26,27]

6. **Address side effect concerns and offer resources** – In the context of COVID, 76% of vaccine hesitant folks in April expressed some concern about safety, often connected to the sense that the vaccine development process was too fast.[12] You can also refer nervous patients to the CDC's V-safe app, which is voluntary, and patients can opt out any time. During the first week after the first dose of a vaccine, V-safe sends brief daily text check-ins to monitor symptoms for the first week, and then weekly for 5 weeks with one dose, and 6 weeks with two. They will also be checking in at 3, 6 and 12 months after the final dose.[28] Discuss that the Johnson and Johnson vaccine pause was actually a reflection of the system working, and encourage patients with concerns about side effects to report them to the Vaccine Event Reporting System.[2,11] Some clinicians approach the uncertainty about long-term impacts by pointing out that while much is unknown about the medium and long term effects of the vaccines, much is known about the short, medium and some suspected long-term effects of COVID.[11]
7. **Tell stories in addition to giving data** – Sharing that clinicians have gotten vaccinated, for themselves and their families, can be persuasive with concerned parents.[2,3] Additionally, stories on social media often focus on the worrisome outcomes of the vaccine, so clinicians telling (anonymous) stories about patients who have had poor outcomes from COVID can be effective for patients who do not know anyone personally affected by the virus.[1,11]
8. **Focus on the freedom the vaccine will give your patient** – Many vaccine hesitant individuals are resistant to and worried about being forced into behaviors.[4,11] It may be helpful to focus on the specific challenges your patient has faced during the pandemic and emphasize how the vaccine will open new opportunities. Ask how they've been coping, or what they miss most about pre-pandemic times.[29]
9. **Focus on protection to loved ones** – This can be effective with childhood vaccines,[3] but also shows promise in persuading populations who have strong concerns about their right to independence during the course of the pandemic.[9,11] Public health messaging has focused on this, and studies have found that protection of loved ones can be a motivator for changes in COVID-related behavior among those who are otherwise less concerned about their own risk.[30]
10. **Listen and continue the conversation** – Facts alone will not persuade some people. But many patients have said they would get the vaccine if it was offered at a routine doctor's visit, and clarifying misinformation is effective at changing minds for individuals who are on the fence.[30]

Table 1: Comparison of U.S. COVID-19 Vaccines, including Efficacy and Demographics (18-27)

	Pfizer	Moderna	Johnson and Johnson	Sources
Official name	BNT162b2	mRNA-1273	JNJ-78436735, Ad26.COV2.S	
Type	mRNA	mRNA	adenovector	
# Doses	2	2	1	
Dosing	3 weeks apart	4 weeks apart	NA	
Date of EUA	12/11/2020	12/18/2020	2/27/2021	18-20
Ages	12+*	18+	18+	
Target	Spike protein	Spike protein	Spike proten	18-23
# Participants in EUA	37,586	30,351	43,783	18-20
Where	U.S. (77%), S. Africa (2%), Argentina, Brazil	U.S. (100%)	U.S. (44%), S. Africa (15%), South America, Mexico	18-23
Race	10% AA, 4% Asian, <1% NA, <1% PI, 82% white, 3% other	10% AA, 5% Asian, <1% NA, <1% PI, 79% white, <3% other	17% AA, 4% Asian, 8% NA, <1% PI 62% white, 5% multiple	21-26
Ethnicity	26% Hispanic	20% Hispanic	45% Hispanic	21-26
Ages	79% 16-64, 17% 65-74, 4% 75+	75% 18-64, 25% 65+	67% 18-59, 34% 60+, 4% 75+	21-26
Gender	49% female	47% female	45% female, <0.1% unk	21-26
Prevent lab + COVID	95%	94.10%	66.3% (77%)	21-26, (27)
Prevent severe/critical disease (after 14 days, 28 days)			77%, 85%	20,23
Prevent Hospitalization in U.S. subjects	94-96%			27
Prevent asymptomatic infection	80-90%	80%		27

AA = African American, NA = Native American, PI = Hawaiian and Pacific Islander
* FDA EUA for 12-15 yo Pfizer was May 10, 2021 (5)

Common Concerns to Consider

Common concerns from COVID vaccine hesitant individuals include:

- fear of serious side effects
- concerns about the development and approval process
- concerns about getting infected from the vaccine
- lack of concern about getting sick from COVID
- concerns about efficacy
- that the vaccine may be worse than COVID itself
- being forced to get the vaccine[12,31]

One poll found that 62% of white unvaccinated respondents, 57% of Hispanic and 54% of Black respondents were concerned about being forced to get the vaccine, and concern about effects on future fertility was the third most common concern across all three groups among 18-49-year-olds.[12] It's worth noting that even among those in November who said they planned to get a vaccine when it became available, only 58% cited confidence in the vaccine development and approval process.[31] Some messages have been found to be more effective than others at persuading vaccine hesitant individuals. It's worth noting that even among the most resistant category (the "definitely not get the vaccine" group), some members can be moved with the right information (See Table 2).[30] Emphasizing the efficacy of the vaccines at preventing death and hospitalization is particularly effective across all three groups.[30]

Concerns about access are also still an issue for many, and an April poll by the Kaiser Family Foundation found that 64% of Hispanic unvaccinated respondents, 55% of Black, and 41% of white cited missing work due to side effects as a concern about the vaccine. Black and Hispanic respondents also had higher rates of concern around finding a trustworthy location, cost, taking time off work and transportation to a site. About one third of respondents in all three groups had concerns about the need to show ID to get the vaccine.[12]

Hispanic individuals are more likely to be worried about getting COVID and to have had someone in their household test positive for COVID. However, those living in immigrant households are particularly concerned about immigration status and may be unsure if they are eligible for the vaccine.[32] At least half of unvaccinated Hispanic adults responded that they did not know that all U.S. adult residents are eligible for vaccination, regardless of immigration status, and the vaccine is free for all.[30] These concerns are readily addressed in a conversation during a primary care visit, especially if the office has the vaccine available on site.

Distrust of the medical establishment is also part of the issue. In November, just 43% of white and 33% of Black respondents to a Pew Research survey reported a "great deal of confidence that medical scientists will act in the best interests of the public," and only 54% of Democrats and 36% of Republicans said the same.[31] Republicans in a poll in January rated lower levels of trust than Democrats in every government source of health and science information (ranging from 47-62%, vs. 81-93%), except for Donald Trump (rated 78%).[31]

However, both groups trusted their own doctor or health provider more than any other individual or organization (81% for Republicans and 93% for Democrats).[31]

Who is Vaccine Hesitant?

Currently, groups with high rates of COVID vaccine hesitancy continue to include Black Americans, women more than men, and rural Americans, especially essential workers not in health care, white Evangelicals, Republicans and young people.[12] Recent polls suggest that Hispanic populations have had more concerns about access,

continued on page 14

Table 2: Percent who say they are more likely to get the COVID-19 vaccine if they heard the following (30)

	Wait and See	Only if Required	Definitely Not Get
The vaccines are nearly 100% effective at preventing hospitalization and death from COVID-19	66%	42%	8%
Although the COVID-19 vaccines themselves are new, scientists have been working on the technology used in these vaccines for 20 years	49%	39%	6%
More than 100,000 people from diverse backgrounds and ethnicities particpated in the vaccine trials	43%	28%	2%
The vast majority of doctors who have been offered the vaccine have taken it	43%	29%	3%
There is no cost to get the COVID-19 vaccine	41%	40%	1%
While the long-term effects of the vaccine may be unknown, the long-term effects of COVID-19 could be worse	35%	35%	3%
Even though most people who die from COVID-19 are older or have other health conditions, some young and healthy people have also been hospitalized and died from COVID-19	31%	26%	1%
The main reason the COVID-19 vaccines were approved so quickly is because red tape that is usually part of the development process was removed, not because corners were cut	28%	18%	2%
% who say they would get the COVID-19 vaccine If offered at their usual place of health care	50%	32%	1%

continued from page 13

including worries about immigration status, and as of May, unvaccinated Hispanic adults are nearly two times more likely than unvaccinated Black adults and three times more likely than white respondents to say they'd like a vaccine as soon as possible.[30]

There has been an effort in recent years to de-polarize the language around vaccine hesitancy.[2] Research has shown that just a small group of people are truly and unmovably anti-vaccine, and this is also proving true with COVID, as the number of hesitant individuals has steadily decreased over time. Many have vague concerns and are open to new information. Others have specific concerns and are well-informed but may change their minds if a clinician has a thoughtful and educational conversation.[2,3]

If a clinician is a member of one of the more hesitant demographic groups, their recommendation would be particularly powerful, in a clinic setting, but also in a more public space, such as through town meetings or local media outlets.[29] There have been numerous efforts to engage with these groups, including recent PSAs by the Kaiser Family Foundation featuring Black and Hispanic clinicians, and other outreach targeting country music stars and the evangelical community.[33,34,35,36]

Conclusions

Family doctors are in a unique position as patients' most trusted source of information about the COVID-19 vaccines, and a potential distributer of the same vaccines. We often have relationships built over years with our patients, as well as being leaders in our communities. In an era of disinformation, this is an incredible opportunity to make an important impact. They're listening. It's important that we talk.

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For additional endnotes and resources, see page 51.

***Francesca Decker, MD, MPH**, is a family doctor currently working at Cornell Health, which is Cornell University's student health center. She is also a project director for COVID-risk related primary care research with the University of Colorado's Department of Family Medicine. She recently completed Harvard University's Media and Medicine certification program and has been working to educate the general public about COVID-19 throughout the pandemic.*

TWO VIEWS:
COVID Pivots – Doing Things Differently

VIEW ONE

ADVANCEMENTS FROM NECESSITY: THE ROLE OF TELEHEALTH IN A FQHC DURING THE COVID-19 PANDEMIC

By Shery Goril, MD; Kenyani Davis, MD and Lavonne Ansari, PhD

The spark of the COVID-19 global pandemic in early 2020 highlighted the need for new healthcare delivery platforms, leading to the rapid development and expansion of telehealth practices. This evolvement contributed to the dramatic transformation of primary health care practices across the United States, which were long overdue. In response to soaring COVID-19 infection rates, many health centers across the nation were challenged to quickly re-evaluate how to best care for underserved patient populations safely and effectively. Mandatory lockdown orders and pandemic threat levels meant that virtual visits were often the only way to ensure comprehensive healthcare. Fueled by necessity, these advancements positively bridge significant gaps in care in a federally qualified health center (FQHC) population that is known to already have significant barriers to accessing affordable, quality health care. This article will describe the development, experiences, and innovation that telehealth services brought to the patients and staff of the Community Health Center of Buffalo (CHCB), a Western New York FQHC.

Initially all telehealth calls were regarding COVID-19 concerns. However, as the pandemic showed no signs of slowing down, telehealth was used for addressing a wide variety of additional medical concerns. It was clear that telehealth would play a pivotal role in delivering quality care to our most vulnerable patients, especially those that were unable to come into the office for an appointment for a wide range of reasons including lack of transportation, childcare commitments, and the fear of contracting COVID. As a federally qualified health center, CHCB serves patients who are disproportionally affected by health disparities. For this vulnerable population, missing an appointment that addresses their chronic conditions can be detrimental. Providers quickly adapted and transitioned to telehealth appointments to ensure that patient care remained as stable as possible. Apart from COVID concerns, telehealth appointments began to focus on all types of visits, ranging from managing chronic conditions to acute visits. Today, CHCB offers options for virtual visits for almost all types of clinical visits, and even has a complete clinical session solely for telehealth, focusing on same day concerns.

The incorporation of telehealth into daily practice contributed to the successful development of a chronic disease management program. This program focused primarily on the management of type 2 diabetes, ranging from pre-diabetics to those with uncontrolled diabetes. This team based approach incorporated the expertise of physicians, a clinical pharmacist, as well as a nutritionist. The use of telehealth contributed to high patient compliance. A clinical pharmacist followed patients closely, providing clinical recommendations for titration of medications. This was convenient for patients who would have otherwise had difficulties attending multiple in-office appointments. Frequent nutrition telehealth visits were also highly effective at keeping patients on track with their goals. The ability to access all these resources remotely contributed to overall improvements in HbA1c measures in many individuals. Without telehealth services, these complex patients would have faced great challenges in

continued on page 16

VIEW TWO

IMPACT OF CONVERTING ASYLUM EVALUATION VISITS TO A TELEMEDICINE FORMAT: LESSONS LEARNED FROM THE COVID-19 PANDEMIC

By Ifeoluwa Adelugba; Megan Bouyea; Divya B. Dasani; Kristiana Hanna; Aishwarrya Jayapal and Katherine Wagner, MD

Introduction

The COVID-19 pandemic amplified the challenges individuals already faced with accessing healthcare. In the last year, telemedicine has become a widely accepted alternative to in-person evaluations across many medical disciplines.[1] Asylum medicine is one such discipline impacted by the adoption of telemedicine visits to address access to health-care challenges.[2]

Asylum is a protection granted to someone who meets the criteria of a refugee, including those who have escaped their country of origin in fear of persecution based upon political beliefs, race, religion, nationality, or identification with a particular social group.[3] When applying for protection, applications are strengthened with evidence collected through medical and psychological evaluations. An evaluation lasts for 2-3 hours and involves a physician, resident, scribes, the client, and, occasionally, a translator. Following the evaluation, scribes will write an affidavit describing the client's story, evaluation, and reason for seeking asylum. Research to assess the advantages and disadvantages of utilizing telemedicine in evaluations for asylum seekers is lacking.

The Capital District Asylum Collaborative (CDAC), a medical student-run organization in the Capital Region offering pro-bono evaluations to asylum seekers, successfully adapted to telemedicine to continue evaluations amidst COVID restrictions. Asylum seekers are an important population to consider when assessing telemedicine utility because of the unique barriers they face due to their non-refugee, non-citizen status and limited access to appropriate healthcare. The impact that telemedicine would have on the quality, efficacy, and outcomes of asylum evaluations was unclear and necessary to evaluate through this study.

continued on page 16

continued from page 15

attending all scheduled appointments. Further retrospective studies may explore the degree of improvement in these measures.

Virtual visits were highly effective across all of CHCB's specialty care departments, including family planning, dentistry, pediatrics and general adult medicine. CHCB's Behavioral Health Department, consisting of psychiatrists and counselors, saw great improvements in providing care to a very challenging population. Given that a large proportion of the clinic's patients have a mental health diagnosis, the ability to continue to provide mental health services throughout the pandemic was essential. Prior to the availability of telehealth, patients often had high no show rates. The incorporation of telehealth broke down significant barriers for patients to be able to have direct access to counsellors and psychiatrists. Subjectively, patients expressed appreciation for this improved access to care. Many patients expressed feeling more at ease having counselling sessions from the privacy and comfort of their homes. CHCB's Dental Department also benefited from access to telehealth. Tele-dental visits were also highly effective to triage dental emergencies during the peak of COVID. This allowed for risk stratification given the higher risk involved in seeing patients for dental procedures.

Telehealth has proven to break down barriers that a FQHC patient population faces, and has allowed for improved patient continuity. The flexibility of scheduling a virtual visit ensures that a patient will be able to follow up with their regular provider and enhance continuity of care. Telehealth has also improved no show rates at CHCB. Once barriers were removed, patients were more likely to comply with phone or video appointments, and as a result were more likely to comply with their treatment plans. Telehealth has also contributed to efficiency in seeing patients by reducing waiting times in the waiting room, as well as the need for ancillary staff. As a result, a higher number of patient visits were facilitated.

Although the initial circumstances were challenging, the emergence of telehealth in our federally qualified health center has served to minimize health disparities and bridge gaps in care. Now, it is hard to imagine a practice without telehealth capabilities. Arising from true necessity, the advancements of telehealth have forever changed the landscape of high-quality medical care.

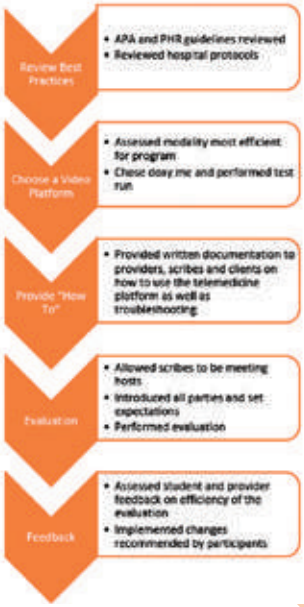
Shery Goril MD, MS *is a board-certified family medicine physician and medical clinical lead at the Community Health Center of Buffalo, Niagara Falls site. She graduated from the University of Buffalo Family Medicine Residency Program in 2019 and was awarded the Erie County Medical Center Excellence Award. She received her medical degree from Saba University School of Medicine, after completing her bachelor of science and master of science degrees with distinction at the University of Toronto. Dr. Goril was one of the pioneers of the telehealth program at the Community Health Center of Buffalo.*

Kenyani Davis, MD, MPH *is the Chief Medical Officer of the Community Health Center of Buffalo with the overall responsibility for the provision of safe, effective healthcare services to patients in the Buffalo, Cheektowaga, Lockport and Niagara Falls facilities. She also serves as Director of Employee Health, in addition to leading research efforts for CHCB. Dr. Davis completed her Doctor of Medicine degree with high honors in 2012 from Ross University School of Medicine, Commonwealth of Dominica, West Indies.*

LaVonne Ansari, PhD *is the Chief Executive Officer of the Community Health Center of Buffalo, overseeing operations at the Buffalo, Cheektowaga, Lockport, and Niagara Falls facilities. She has served in a wide range of roles throughout her community in the areas of education, health, equity and diversity, and cross-cultural communications. Dr. Ansari received a master's degree in multidisciplinary studies from Buffalo State College and a PhD in the sociology of education at the State University of New York at Buffalo.*

continued from page 15

Figure 1. *General Protocol Used by CDAC*



Methods

CDAC drafted a telemedicine protocol using guidelines published by the Physicians for Human Rights (PHR) and the American Psychological Association (APA) organizations.[4,5] Adaptations made from these guidelines helped CDAC determine the best practices for virtual evaluations (Figure 1). This included the following criteria: virtual platform selection, technology accessibility, provider comfort with virtual evaluations, previous telemedicine experience, and client privacy measures.

A variety of HIPAA-compliant virtual platforms were considered; however, Doxy.me was selected for its optimal security measures and easy-to-use functions suitable for most users. A test run was conducted using Doxy.me followed by establishing a backup plan for situations of video failure. Audio-only evaluations using conference call methods and FaceTime were selected as backup methods. User instruction guides were drafted prior to finalizing the telemedicine protocol.

To assess the utility of using virtual methods to conduct evaluations for asylum seekers, voluntary feedback was collected via email from providers and medical student scribes. Feedback addressed the following factors: efficiency and duration of evaluation, ease of use of technology, provider comfort, and willingness to continue using telemedicine platforms. Additional variables, including annual and total caseload, were evaluated using Microsoft Excel to understand the impacts of telemedicine on workflow during the pandemic.

Results

Since its inception in 2016, CDAC has evaluated a total of 54 clients to date. CDAC evaluated 6% (n=3) of the total cases in 2016, 13% (n=7) in 2017, and 20% (n=11) in 2018, with the largest caseload of 31% in 2019 (n=17) (Figure 2). Despite a temporary suspension in Spring 2020, CDAC maintained its caseload during the pandemic at 30% (n=16). Although all evaluations were halted at the start of the pandemic, CDAC compensated for lost evaluation time with telemedicine visits starting in August 2020.

Feedback provided in the post-evaluation surveys described the advantages of virtual evaluations, including improved evaluation efficiency and satisfactory quality (Table 1). One provider stated, *"It was nice to get a glimpse into the houses/lives of our clients. Understanding their home situation added to my grasp of their life."* Another stated they *"did not feel there were many advantages to telemedicine for these evaluations, but the ability to do them was crucial during the pandemic, which otherwise would have halted the asylum process for many families."*

Disadvantages included technological errors and decreased appreciation of clients' physical, nonverbal, and social cues. All providers and scribes stated they would use telemedicine to conduct a future asylum evaluation.

Figure 2. *Number of Evaluations Conducted through CDAC Each Year.* Each year indicates how many evaluations were complete at the end of the calendar year. The arrow indicates the onset of the pandemic, however, maintenance of growth is indicated by the relative plateau seen at the end of 2020.

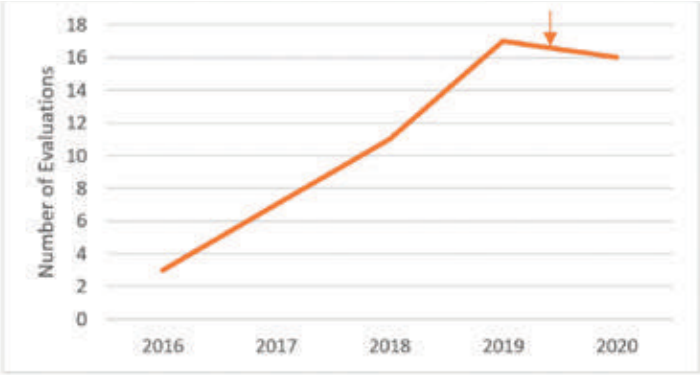


Table 1: *Provider and Student Feedback Post-Evaluations.* A) Describes key positive and negative comments collected from all 4 providers who conduct evaluations with CDAC. B) Describes key positive and negative comments collected from 6 student scribes. Feedback was collected via email immediately following the evaluation.

Provider Feedback Received	Student Feedback Received
Effective? Yes (N=4)	Effective? Yes (N=6)
Advantages • *Ease of access for clients* • *Scheduling flexibility* • *Travel time not an issue* • *Comfortable environment for clients* • *Less tangential* • *More methodical*	Advantages • *Logistically easier* • *Ability to continue evaluations during COVID* • *Maintaining social distancing* • *Slow pace of evaluation allowing "near verbatim" transcription*
Disadvantages • *Digital divide concerns* • *Less optimal mental status exam* • *Video interface connection* • *Client lack of privacy when home*	Disadvantages • *Difficulty appreciating emotions* • *Technical difficulties*
Suggestions • *Improve internet connectivity* • *Provide meeting information ASAP*	Suggestions • *Encouraging a private environment for client*

Discussion

Telemedicine allowed CDAC to maintain its growing caseload despite the challenges faced during the pandemic. Medical and psychological evaluations increase asylum acceptance chances from 37.5% to 89% with an evaluation. The inability to perform any evaluations during the pandemic would have affected asylum approvals.

Accessibility to asylum evaluations for this population was challenging before COVID due to socioeconomic disadvantages, limited access to transportation and childcare, and communication barriers. Data from this study suggests some barriers were reduced, while others were not. Telemedicine relieved challenges of arranging transportation and childcare for evaluations. Communication remained challenging due to limited access to internet connectivity and translation services.

In the context of asylum evaluations, a benefit of telemedicine is how it offers the option to modify visits to adjust to clients' available resources. For example, one can convert to audio-only visits if visual connectivity is unavailable, translator location can be varied (to be with the client, the physician, the scribe, or on their own virtually), and appointment times can be changed if a virtual connection is challenging.

This allowed for increased flexibility to schedule more evaluations each week. Prior to the use of telemedicine, in-person evaluations were challenging to arrange due to limitations involving arranging for client and scribe transportation, reserving examination rooms, and provider office availability. Scheduling used extensive student administrative time, limiting availability to 1-2 evaluations per week. Telemedicine alleviated the need to address many of these factors; one week, CDAC conducted five evaluations. However, telemedicine creates a different set of challenges that make asylum psychological evaluations difficult. This includes a relative inability to appreciate clients' non-verbal cues.

As the cases are presented in court and verdicts are reached, CDAC plans to compare the success rates of affidavits written using telemedicine and in-person evaluations. Based on the positive impact that telemedicine has had on CDAC's program, other asylum clinics may benefit from implementing similar technologies. The asylum seeker population is vulnerable and at risk for increased health disparities if additional barriers hindering access to evaluation resources are not addressed. The family physicians and psychiatrists who conduct evaluations for the clients at CDAC worked tirelessly to address the needs of this unique population, even throughout the pandemic. While small in size, this study highlights the opportunity to provide accessible and equitable care to such populations during the pandemic via telemedicine.

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Ifeoluwa Adelugba *is a student at Albany Medical College. She completed her undergraduate studies at Siena College with a BA in Biology and a minor in political science Her professional and research interests include women and children's health, and immigrant health. Ife is a member of the Student Council and worked alongside peers to create an annual student-run advocacy committee and lobby day. She is a*

continued on page 18

continued from page 17

leader in the Physicians for Human Rights chapter, and serves as a legal liaison in her school's asylum clinic. Ife looks forward to working in multiple spheres of influence as a physician and helping to bring about policy change on behalf of the most vulnerable populations.

***Megan Bouyea** is a rising third year medical student at Albany Medical College. She grew up in East Greenbush, NY and graduated from Siena College in 2019 with a Biology BA. During her time at Albany Medical College, she has been actively involved with Capital District Asylum Collaborative in her role as Physician Coordinator and will soon transition to a role as an E-Board member. Megan is passionate about service and is eager to use her medical education to provide care to underprivileged populations as a future physician.*

***Divya Dasani** is a rising MS4 at Albany Medical College who graduated from Siena College with a BA in Biology. Before starting medical school, Divya took a gap year during which she spent time researching at a hepatology clinic in New York City, and on a service trip to Oaxaca, Mexico, where she taught children and single mothers. Divya began working with the CDAC program as an MS1, has served as a physician coordinator of the program and is now one of the research coordinators and executive board co-directors. As Divya moves into residency, she will continue to focus on addressing language barriers and improving access to continued medical care for asylum seekers, refugees, and other marginalized populations.*

***Kristiana Hanna** is a rising MS4 at Albany Medical College who graduated from Siena College with a BA in Biology. She focuses much of her work and research at Albany Medical College on service with an emphasis on legislative lobbying, education around advocacy, translation quality improvement, and asylum rights. She began working with asylum seekers through the work of Capital District Asylum Collaborative, where she was the legal liaison and now is part of the executive board. Through numerous leadership positions, she plans to continue her service work throughout her future practice as a primary care physician.*

***Aishwarrya Jayapal** is a current M3 at Albany Medical College. She graduated with a BS in Neurobiology-Physiology and a BS in Psychology from the Honors College at the University of Maryland, College Park. She is passionate about the field of pediatrics and volunteers her time cuddling sick newborns at the Albany Med NICU and conducting research on pediatric respiratory interventions in a critical care setting. She has been involved in the Capital District Asylum Collaborative as Student Coordinator of the executive board and a co-lead for the American Women's Medical Association chapter at Albany Med. Through her leadership and investigative involvements, she hopes to continue her interests in community service, education, and discovery as an aspiring pediatrician.*

***Katherine Wagner, MD** is Vice Chair and Director of Community Outreach in the Department of Family & Community Medicine at Albany Medical College in Albany, NY.*

Upcoming Events

2021

Aug 7-8
Summer Cluster
New York Marriott
Downtown (NYC)

Nov 7
Fall Cluster Board Only
Hilton Garden Inn
Albany Med.
(Commissions to meet virtually prior to Nov. 7)

2022

Jan 13-16
Winter Weekend
Saratoga Springs

Feb 27-28
Winter Cluster and Lobby Day
Renaissance Hotel
Albany

May 21-22
Congress of Delegates
Desmond Hotel
Albany

For updates or registration information for these events go to www.nysafp.org

IN THE SPOTLIGHT

Two NYSAFP members, Dr. Tochi Iroku-Malize and Dr. Sarah Nosal are running for AAFP President-Elect, and for the 2021 AAFP Board of Directors, respectively. The following tributes have been written by their peers. You will find additional information about their candidacies at www.nysafp.org.

Someone to Admire

I have always been drawn to strong, intelligent, independent women. My wife, Jen, is a testament to that fact. Even from a young age, their confidence always inspired me. In high school there was Cresta, Kai, Keisha, Kristin, Nehad and Olaya. In college there was Mary, Allison, Carla, Adrian and Melissa. In medical school it was Susan, Gina and Robin. And since becoming a family physician and joining the American Academy of Family Physicians, there's Sarah, Jen, Tobie, Lori, Marie, Kim, Christine, Margot, Vickie and Barbara. Of course, I have known countless other awe-inspiring female colleagues who I am proud to call friends. Undoubtedly one of the most impressive women I have had the privilege of knowing is Dr. Tochi Iroku-Malize. Her brilliance, energy and dedication have produced a steady stream of amazing and jaw-dropping accomplishments. Her kindness, understanding and compassion have endeared her to friends and colleagues. Her courage and tenacity have inspired those of us who have known and worked with her within the NY chapter.

Dr. Iroku-Malize is remarkable, but not because she is a family doctor, caring for patients and teaching the next generation of family doctors. If that were all, it would be enough to impress anyone. What is really impressive is the sheer volume of knowledge, skills and experience she has acquired throughout her education, career and life.

In her career she has been a solo practitioner, providing care to her patients at her office, in their homes, in a nursing home and while they were hospitalized. This comprehensive care metamorphosed into a career as a hospitalist when the field was brand new. She helped shape the new specialty into what it is today. Her leadership paved the way for family physicians to be at its forefront and continue to provide critical hospital care. At the same time, she continued as an active faculty member at the residency which trained her. Eventually, through these continued efforts, she became the residency program director and through her ongoing efforts and various leadership activities, she molded the residency curriculum used to educate and train our young family medicine colleagues. And along her clinical medicine journey, her dedication to patient care and the education of young family physicians compelled her to become board certified in both hospice and palliative care, and family medicine.

By that time, her accomplishments had already eclipsed most of our family medicine colleagues, but was she satisfied? No! Through sheer skill, talent and dedication to the ideals of family medicine, she became the Senior Vice President of Family Medicine at Northwell Health and their inaugural Professor and Chair for the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

Her desire to educate and become educated did not stop there. She has worked tirelessly to help improve the care of, not only her patients, but people throughout the world. She is passionately committed to extending healthcare to people in underserved and distressed areas around the globe. I vividly recall reveling in her glowing conversation during a meal together, when she had to take a call as she played the part of trouble shooter for a new residency rotation she was creating in Haiti. For her, the daughter of a physician and nurse practitioner, this was second nature. Later that night, I found out that she had also worked extensively to train family physicians in the Dominican Republic, Kenya, and her parent's native home of Nigeria (and I recently found out she is now starting to work with training programs in Ecuador and Guyana as well). Talk about caring for our neighbors and each other! I have always believed in the ideal of caring for the community which cares for us. Never before, however, had I witnessed someone so committed to actually fulfilling that aspiration on a global scale.

continued on page 20

continued from page 19

But even so, if that were all, it would have been enough, but that is not all. Tochi continues to be involved in all aspects of family medicine. Not just global health, but also clinical informatics, medical genomics, telemedicine, women and children's health, special needs populations, cultural competency, health equity, research and family medicine advocacy and leadership. Incredibly, she augmented her already impressive portfolio of accomplishments and skills, by obtaining an MPH in health policy and management and an MBA, even as she remained current in her medical education.

Through her efforts, she has been able to touch innumerable lives. Her role as a board member for the American Academy of Family Physicians was a natural extension of her drive to help her fellow family physicians and patients and she has remained a strong voice in those efforts. She is thoughtful and pensive when considering all information in making decisions, yet passionate, dedicated and motivated to overcome any obstacles. Her decision to run for president-elect of the AAFP makes my heart sing as our strong, unified Academy needs her leadership.

As I mentioned before, I have always been drawn to strong women, but not all have been or were willing to be leaders. I find solace in knowing that Dr. Tochi Iroku-Malize has volunteered her countless abilities and boundless energy and passion to propel family medicine into the future. Knowing that she is looking out for us all helps me sleep better at night and reinforces my decision to try to live up to her standards. If I can attain only a fraction of her accomplishments, then I would consider myself successful.

– Marc D. Price, DO
Past President, NYSAFP
AAFP Delegate

Inspiration

Dr. Sarah C. Nosal is a transformative leader. The New York State Academy of Family Physicians proudly nominates Dr. Nosal for Director of the AAFP Board because our leadership and our members are astutely aware of her approach to organizational change. She is an open-minded arbiter who listens to others, appreciates their contributions, and seeks to understand their viewpoints. Then, internalizing all of the best information, she leads with tenacity and determination. She holds the particular distinction of being the youngest President in the history of the NYSAFP because of the respect she garnered from her peers for always representing their best interests, even when they were in conflict with her initial leanings. But, I cannot alone do justice to all of the aspects of Dr. Nosal's exceptional skillset, knowledge, and experience, so I have asked several other colleagues to provide their thoughts and insights.

"Dr. Nosal has been my greatest mentor within the NYSAFP. She is extremely approachable, genuinely cares about empowering student voices, and unabashedly serves as a connector of people. Since my first day with the Academy, I've witnessed her kindness and energy light up the room at every single board meeting and conference I've attended. Dr. Nosal is the reason I have pursued and will continue to pursue more advocacy opportunities with the AAFP. She challenges those around her to be better and to fight for our patients and colleagues. She is literally the family physician-leader I dream of being one day!"

– Allyssa (Ally) Abel, MD, MPH
Christiana Care Emergency Medicine/Family Medicine PGY-1

"Sarah demonstrates outstanding commitment to equity and inclusion, being sure to lift up all voices and especially those that aren't always heard. She also has demonstrated a consistent commitment to furthering the mission of our Academy and advancing family medicine as a specialty. In her service as a Commission member, Board member and past President, her dedication to our mission, vision and values has been unwavering."

– Scott Hartman, MD, FAAFP
Board Member, NYSAFP
Associate Clinical Professor of Family Medicine
University of Rochester Medical Center

"I have known Sarah Nosal since she was an intern, so about 15 years. She is an IT whiz. As chief resident she revamped our FQHC's internal home page with links and references to anything we could possibly need. As an attending, she has stuck by her Bronx practice, defending health care for our medically underserved community and leading students and residents toward involvement in the AAFP. She sets a high standard, believing strongly that those least fortunate deserve health care that is as good as, if not better than, those in the ivory towers. She puts her brilliance to good use, creating the systems to make that high-quality health care happen and to hold all of us accountable. She advocates for health care access for those marginalized, whether it be HIV care, reproductive health care, LGBTQ care or addiction care and walks the walk by providing this care herself and teaching others. She is a strong and respected leader who brings much to the table."

– Linda Prine, MD, FAAFP
Professor of Family and Community Medicine,
Mt. Sinai School of Medicine
Mt. Sinai Downtown & Harlem Family Medicine Residency
Reproductive Health Director
Institute for Family Health

"Sarah was NYSAFP Membership chair the first year I was on a commission. I was a PGY2 and didn't know anything about NYSAFP or AAFP. She made me feel welcome and included from our very first meeting. More recently she was the person I selected as Parliamentarian to assist me as Speaker for our Congress of Delegates. Her knowledge about parliamentary procedure and her ability to communicate that knowledge were truly invaluable to me. She has guided and encouraged me along my journey at NYSAFP and AAFP and I know she has helped many others as well."

– Rachelle Brilliant, DO, FAAFP
Speaker, NYSAFP

"Born in Tennessee to a Baptist minister and a nurse, the importance of family, hard work and respect were the lessons I learned growing up and define the core of who I am and who I strive to be.

Holding my hand as we walk through the tangled blocks of New York City, my wife, Dr. Sarah Nosal, gives me a squeeze when she notices an individual experiencing homelessness. She will ask their name, notice their feet and she will reach into her bag. She hands me a stuffed zip lock pouch - of socks, soap, cream, poncho and post pandemic, masks. I see the world differently when I walk with her.

For some, family medicine is the essence of their being. It is so tangled up in who they are and how they share and experience the world, you cannot imagine them doing anything else. For Sarah it is all these things but especially how she shares, inspires and takes hold - getting you to where you want and need to be, together."

– James Mumford, MD
President, NYSAFP

"Since joining the a NYSAFP four years ago, I've worked with Dr. Nosal in various capacities at the city and state level. She wholeheartedly supports and advocates for her patients, colleagues, and chapter, as well as mobilizes others to collaborate towards a common goal. Regarding social and racial equity, she is a strong ally who is willing and able to have discussions where opinions differ, and proactively seeks ways to educate herself and others. Sarah believes strongly in the value of primary care and advocates for family medicine, even when those around her are not as hospitable. Dr Nosal is undoubtedly a strong leader who has innovative and inclusive ideas that will help guide our organization in the years to come.

Understanding the importance of engaging feature leaders, she also encourages and mentors physicians like me, to run for leadership positions and help shape AAFP as well."

– Ivonne McLean, MD
Chair, DEI committee
NYSAFP Board of Directors
Past co-chair Leadership Commission & DEI Task Force
Faculty, Harlem Residency in Family Medicine

"As I ponder Dr. Sarah Nosal, one word continuously comes to mind: Empathy. One may think I'm referring to Dr. Nosal's uncanny skills in connecting and communicating with her patients, making her a prototypical, caring family physician. But thinking that empathy was only extended to her patients would be incorrect. Sarah also extends that empathy to all of those around her and especially to those who share her profession – all veins of it. Despite being part of a larger family medicine organization, she vigorously advocates for small, independent practices in their abilities to care for their local populations and to continue to provide crucial services within their communities. Dr. Nosal truly is a physician who cares. Cares for her patients, her community and the house of family medicine."

– Marc D. Price, DO
Owner, Family Medicine of Malta
Past President, NYSAFP

"Dr. Sarah Nosal is a family physician with a gift for connection, and I have both witnessed and benefitted from her sharing this gift. Over the past decade, I have watched her build consensus among colleagues and across specialties to advance health equity, build bridges with policymakers to increase funding for family medicine, build pipelines for enthusiastic students to become family medicine leaders through NCCL, build access to care for uninsured patients through free clinics, and build community through peaceful protest. Wherever I see her- on the street, in the clinic, on the floor of congress or in a board room—Dr. Nosal is deftly wielding her power to connect. And by doing so, she gives me hope that for our specialty, the best is yet to come."

– Anita Ravi, MD, MPH, MSHP, FAAFP
CEO, Co-Founder, PurpLE Health Foundation

As a state chapter, our duty is to find our most talented members and grow them into leaders to help the AAFP achieve organizational greatness. Dr. Sarah C Nosal is one of those rare talents that can help AAFP achieve its mission and vision, and in so doing, will help our members reach their maximum potential. We enthusiastically endorse her candidacy.

– Jason M Matuszak, MD, FAAFP, FAMSSM
Immediate Past President, NYSAFP
Chief of Sports Medicine, Excelsior Orthopaedics

South Bronx Patient and Provider Attitudes Toward the Covid-19 Vaccine: An Exploratory Comprehensive Survey

By Arafat Omidiran, MHA; Jessica Bucciarelli, BA; Jose Tiburcio, MD and Douglas Reich, MD

Introduction

It is the clear consensus among public health professionals that a COVID-19 vaccine represents the best hope of stemming the tide of the current global pandemic. The acuity of the pandemic has driven the push for expeditious yet effective vaccines. However, a key challenge is not only the development, but the reception of vaccines by the general public. Vaccine skepticism and hesitancy have long been obstacles to public health. Several years ago, the World Health Organization (WHO) convened a working group called the Strategic Advisory Group of Experts (SAGE) to examine reasons for vaccine hesitancy around the globe and reported their findings over a three- year period from administered surveys.[1]

The COVID-19 vaccines have arisen in very unique circumstances from both political and scientific points of view. Two of the three approved vaccines in the US, from Moderna and Pfizer, are the first examples of mRNA based vaccines, and provide an additional challenge for patient education and understanding. The third approved vaccine from Johnson and Johnson uses the more traditional virus-based technology. A number of surveys have attempted to assess the willingness of recipients to receive a hypothetical COVID-19 vaccine. One such study in France showed a positive correlation with willingness to receive a vaccine based on age and occupation, specifically, healthcare workers.[2] A second published study analyzed responses to an online survey in the US, and indicated that willingness to receive a vaccine depended upon demographics (age/race), political leanings, perceived risk of contracting COVID-19, perceived efficacy of a vaccine and perceived side effects.[3] Results from a third survey also pointed to attitudes about perceived side effects and efficacy being major factors in attitudes about a potential COVID-19 vaccine.[4]

In order to assess the willingness for BronxCare Patients and healthcare providers to receive a COVID-19 vaccine, an anonymous survey was conducted (both in person and online). This survey assessed health related knowledge, attitudes, and practices as well as willingness to receive a COVID-19 vaccine. We believe that this study is relatively unique, in that our population in the South Bronx is 'majority minority', and represents an extensive cultural mix of Latinx, African American, African and Bengali residents. Minority populations have been disproportionately affected by COVID-19 in general, making reception of a vaccine particularly important. Findings from this study are important in the development of patient education as family care providers and institutions continue to roll-out the COVID-19 vaccines.

Methodology

This study was conducted in BronxCare Health System, which is located in the South and Central Bronx and was approved by the institution's Institutional Review Board. BronxCare is one of the largest providers of outpatient and emergency services in the Bronx, with a largely minority patient population that experienced high incidences of COVID-19 infections. All data used in this study was collected through an anonymous survey offered to both hospital patients and providers. The information was collected in a way which prevented researchers from knowing whether respondents were patients or providers. This was done to retain complete anonymity.

The survey was administered in both paper and electronic forms between September 22nd and November 11th, 2020. Patients were informed about the survey while in the waiting room of some of our family medicine outpatient clinics. Respondents received no incentive for participating in the study. Participants were asked about their general knowledge and attitudes towards vaccines as well as their reasons for getting/not getting a vaccine. Similarly, they were asked the same questions about the COVID-19 vaccine specifically. In addition, respondents were asked about their practices since the pandemic began around mask use, social

event attendance, COVID-19 testing and symptoms. Demographic information and questions on perception of risk was also collected.

Statistical Analysis

Frequency tables were created for all relevant survey questions. Descriptive statistics were calculated using the Pearson chi-square test. Demographic variables and survey questions of interest were analyzed against either "Do you get vaccinated?" or "How often do you receive a flu vaccine?" Relevant survey questions included, "Do you believe you are at high risk of contracting COVID-19," "General perceptions of vaccinations," and "Do you believe a COVID-19 vaccine should be mandatory?". Demographic variables included: age, gender, race, education, employment industry, and essential worker status.

Results

A total of 427 participants completed the survey. The largest age group of participants was 18-44, with 216 participants (50.6% of total). 237 of the survey participants were female (55.5%). Black/ African American race had the highest frequency, with 188 participants (44%). College graduates made up the largest demographic group with 107 participants (22.1%), but it should be noted that the variable is bimodal; high school or GED equivalent and master's/ professional degrees both had 99 participants (23.2%). 250 participants reported being essential workers (58.6%). Of the 427 survey participants, 287 reported being employed (67.2%), while 14 participants reported being unemployed due to COVID-19 (3.3%).

When asked about vaccination attitudes and general perceptions about vaccinations, 141 employees reported being "neutral" (33%). In contrast, 62 participants reported being against or strongly against (14.5%), and 193 reported being favorable or strongly favorable of vaccines (45.2%). 203 participants believed that the COVID-19 vaccine should not be mandatory (47.5%).

Participants were asked about vaccination practices. 291 individuals stated that they get vaccinated (68.2%), while 91 individuals do not get vaccinated (21.3%). Participants were also asked how frequently they get a flu shot. The majority of respondents reported that they received a flu shot always (197, 46.1%), followed by 77 participants recording they get the flu shot most of the time (18.0%). 278 participants stated that they wore a mask all the time (65.1%), and 106 participants stated they wore a mask most of the time (24.8%), compared to 4 individuals who reported never wearing a mask (0.9%) or wearing a mask some of the time (13, 3.0%).

The first of the two chi-square analyses tested the relevant variables against "Do you get vaccinated?" Of the 216 individuals aged 18-44, 157 (72.7%) indicated that they do get vaccinated, while 45 (20.8%) do not get vaccinated. 163 of the 237 females who responded to the survey indicated that they do get vaccinated. Education can be used as a predictor for vaccination practices ($p = .005$), and 81 of the 107 (75.7%) college graduates get vaccinated. When testing "Do you believe you are at high risk of contracting COVID-19" against "Do you get vaccinated?" $p < .001$. Of those individuals who responded that they felt they were at "very high risk" (63, 14.8%) 50 indicated that they do get vaccinated (79.37%). Perception of vaccination was also a predictor of vaccine practices ($p < .001$). 103 individuals indicated that they were in favor of vaccination, and 80 of the 103 (77.67%) stated that they got vaccinated. Of the 30 (7.0%) individuals who were "strongly against" vaccination, 8 (26.67%) got vaccinated, and 15 (50%) did not get vaccinated; the remaining 7 (23.33%) refrained from answering the question. "Do you believe that a COVID-19 vaccine should be mandatory?" was another predictor of vaccine practices ($p < .001$). 130 participants (30.4%) believed that the COVID-19 vaccine should be mandatory, and of those, 104 (80.0%) choose to be vaccinated.

The second chi-square analysis tested "How often do you get the flu shot?" against all applicable demographic and survey questions. Gender, race, and employment industry were demographic variables that were predictors for flu shot practices ($p<.001$). Of the 237 female survey respondents, 124 (52.3%) stated that they always receive a flu shot. 75 (39.9%) of the 188 Black/ African American respondents stated that they always receive a flu shot, 36 (19.1%) stated they receive the flu shot most of the time, 27 (14.4%) receive the flu shot some of the time, and 32 (17%) never receive the flu shot. The largest group of survey respondents works in the healthcare industry (239, 56%). Of all healthcare workers, 138 (57.7%) always get the flu vaccine. "Do you believe you are at high risk of contracting COVID-19?" was a predictor of flu vaccine practices ($p<.001$). Of the survey participants who answered "high risk" (135, 31.6%), 75 (55.6%) always receive a flu vaccine. Of the individuals who

continued on page 24

continued from page 23

responded as "very low risk" (40, 9.4%), 21 (52.5%) always receive a flu vaccine. "General perception of vaccines" was another predictor for flu vaccine practices (p<.001). 30 individuals (7.0%) stated that they were strongly against vaccines, yet of these 30, 5 (16.7%) always receive a flu vaccine. "Do you believe a COVID-19 vaccine should be mandatory?" was the final predictor of flu vaccine practices (p<.001). 203 (47.5%) survey respondents reported that they do not believe the COVID-19 vaccine should be mandatory, but 79 (38.9%) always receive a flu vaccine. Of the 130 (30.4%) respondents who believe that the COVID-19 vaccine should be mandatory, 79 (60.8%) receive a flu shot always, and 24 (18.5%) receive a flu shot most of the time.

Conclusion

Findings from this survey have been used to develop and inform the department's vaccine roll out initiatives. Almost half of the survey respondents believed that the COVID-19 vaccine should not be mandatory (47.5%). However, with historical data indicating that over two thirds of the respondents answered yes to regular vaccinations as well as flu shots, it is clear that some respondents who show hesitancy about receiving the COVID-19 vaccine may be convinced with appropriate education and encouragement from their primary care providers. To encourage this, vaccines are made available to patients during their regular outpatient visits. COVID-19 vaccine literature is shared with patients in the waiting rooms of the outpatient clinics, and nurses and providers are encouraged to educate patients on the safety and efficacy of the vaccine, as data shows a "nudge" from a familiar provider might be what it takes to get some patients over their hesitancy. Our survey findings are in line with recent literature which shows "three in ten adults who are not currently convinced to get a COVID-19 vaccine right away say they would be more likely to get vaccinated if their doctor offered it to them during a routine medical visit."[6]

The survey data also confirmed that education can be used as a predictor for vaccination practices (p = .005), as a high percentage (75.7%) of our college educated respondents answered yes to getting vaccinated regularly. Considering the low socioeconomic status and education level of our patient population, these findings strengthened the need for the department's community health workers to be heavily involved in our COVID-19 vaccine education and roll out. Our community health workers are from and live in our communities, so they are able to meet our patients where they are at, breaking down educational, language and cultural barriers. The department currently promotes and offers vaccines to the community via standalone vaccine tents and uses a team approach similar to our outpatient clinics which includes multiple community health workers, nurses, medical students and at least one primary care provider in each tent. Our community health workers educate and correct misinformation about the COVID-19 vaccine while out in the community and are often able to convince family and friends of those getting the vaccine to get one themselves while at our tents.

Lastly, a major predictor of vaccine practices was perception of risk. Our data found that over half of those respondents who considered themselves "high-risk" of contracting COVID-19 always receive a flu vaccine. Interestingly, 7.0% of our survey respondents stated that they were strongly against vaccines, yet 16.7% of these same respondents stated they always receive a flu vaccine. We can conclude that the fear or risk of contracting the flu in this group outweighs their general opposition to vaccines. These findings suggest patients who are opposed to getting the COVID-19 vaccine might be influenced to do so with accurate knowledge on their risk of contracting the virus. As a result, the department's community health workers have been conducting outreach to our patient population via phone calls and letters to help them understand their risk, help build vaccine confidence and access, and recognize the implications of not getting vaccinated. The department is also working with community-based organizations through our partnership with the Claremont Healthy Village Initiative to provide the community with information on eligibility and access to the vaccine. This is especially important for the communities we serve who are at high risk for COVID-19 due to minority and low socio-economic status.

Endnotes

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Arafat Omidiran *directs department research and program evaluations in the Department of Family Medicine at Bronx Care Health System. Her current research focus areas include COVID-19, HIV/AIDS, hepatitis, diabetes, behavioral health initiatives, community health interventions, and LBGTQ health care. She received a Bachelor of Science degree in Health Studies from Concordia College New York and a Master's of Healthcare Administration from Columbia University, NY.*

Jessica Bucciarelli *is a graduate student at the University of Pretoria focusing on modeling elephant movements across southern Africa. She is a consultant for BronxCare doing biostatistical data analysis. She received her Bachelor of Arts from SUNY Purchase in biology and environmental studies.*

Jose Tiburcio, MD *is the Associate Chair and Residency Director of the Department of Family Medicine at BronxCare Health System and has been a practicing family medicine physician for over 20 years in the department. He completed his residency at BronxCare and received his medical degree from the Pontificia Universidad Católica, Madre Y Maestra in Santiago, Dominican Republic, and received a master's degree in healthcare delivery from Mt. Sinai's Icahn School of Medicine. He has been a HIVMA clinical fellow, a mentor to other HIVMA fellows, and continues to be the clinical HIV authority in the department for projects and programs, while also continuing to see and treat patients.*

Douglas Reich, MD *has served as the Chairman of Family Medicine at the BronxCare Health System over the past 15 years. Under Dr. Reich's leadership, the Department has developed a wide variety of creative and innovative programs, including transgender care, the Claremont Healthy Village Initiative, the community health worker program, addiction medicine, an integrative health care clinic, collaborative mental health care services, and comprehensive primary care both in the inpatient and the outpatient environments. The Family Medicine Residency Program has grown to be one of the largest in United States. Dr. Reich and the Department of Family Medicine strive to "improve health care in the South Bronx, one patient at a time."*

An Interesting COVID-19 Case

By Jasdeep Singh Bajwa, DO and Jingnan Bu, MD

This is a 12-year-old male presenting with 2 months of persistent urticarial rash and angioedema. Patient had contracted COVID-19 roughly two months ago and at the time his only symptoms were fevers and an urticarial rash. He had been seen several times by his PCP and was treated with H1 blockers, H2 blockers and most recently with steroids. Despite this treatment regimen his urticarial rash had persisted leading to his parents bringing him in to the hospital.

On presentation he was mildly febrile to 100.3F and tired appearing. His face and lips were grossly swollen and he complained of a "sore throat." There was a diffuse urticarial and blanchable rash on his torso, back, upper and lower extremities including the groin, with mild excoriations. There was visible swelling of the patient's cheeks, eyes, and lips.

The patient was admitted for concerns of multisystem inflammatory syndrome in children (MIS-C). The next day, he admits to some nausea in addition to mild abdominal pain. His rash worsened over his torso and extremities. MIS-C work-up, which included a CBC, CMP, D-dimer, ferritin and fibrinogen were unremarkable other than mild leukocytosis. There was diffuse expiratory wheezing present throughout the left and right lungs. This was a new finding compared to his physical exam on admission the day prior. He was given a dose of epinephrine with complete resolution of his wheezing, improvement of his rash, improvement of his abdominal pain and nausea. The patient's allergic history is notable for seasonal allergies, and hives to azithromycin and penicillin. There was no specific recent trigger, including new detergents, clothes, foods or pets. The only exposure he had was COVID-19 infection two months prior to presentation, confirmed with a positive COVID-19 IgG, and a negative PCR. Subsequent work-up conducted by allergy and immunology was largely negative, including negative mycoplasma pneumoniae IgM and IgG, tryptase, extended upper respiratory viral panel, Monospot, and blood cultures. The medical team confirmed that he had a spontaneous anaphylaxis reaction in the setting of chronic urticaria and angioedema.

The patient was stable for discharge and was sent home with a close follow up with immunology and allergy. Upon discharge he was on cetirizine 10mg twice daily, hydroxyzine 25mg twice a day, montelukast 5mg daily, fexofenadine 180mg twice a day and diphenhydramine as needed. When the patient was seen in the outpatient setting, his Allegra was increased to 320mg twice a day due to continued ongoing urticaria and angioedema. This did not help control his symptoms and his angioedema continued to persist. Subsequently, prednisone 15 mg daily was initiated. His symptoms at the next follow up improved, but he developed side effects from the steroids, which included a Cushingoid appearance and mood swings. The decision was made to start omalizumab 150mg every 28 days. Due to the side effects from the prednisone a steroid taper was started and since initiating omalizumab injections, his symptoms have been stable. The patient has not had another anaphylaxis event since hospitalization. His hives have completely resolved and his angioedema has significantly improved. Given his presentation and trigger for his urticaria and angioedema, the allergy and immunology medical team believes that patient should not receive the COVID vaccine.

From this case, family physicians should appreciate the presence of an anaphylactic reaction in the absence of hyperacute triggers. If a patient is presenting with symptoms that meet criteria of anaphylaxis, treatment with epinephrine should not be delayed, despite the absence of respiratory distress. It is important to highlight that the patient was infected with COVID-19 two months prior to developing chronic urticarial and angioedema which persisted to anaphylaxis. Viral-triggered mast-cell activation is common; however, family physicians should be aware of SARS-CoV-2 as another potential etiology for this, leading to chronic urticaria and angioedema.

Jasdeep Singh Bajwa, DO *is a 2nd year family medicine resident with interests in medical education and clinical reasoning. His passion for medical education not only involves medical students, but teaches his patients to better understand their conditions and management.*

Jingnan Bu, MD *is a faculty member at the University of Rochester Family Medicine Program in Rochester, NY. Dr. Bu received her medical degree from New York Medical College in Valhalla, NY and completed family medicine residency at the University of Rochester. Her academic interests include medical education, health equity, and palliative care.*

Disparities in NYC Communities Hit Hard by COVID-19

By Maria Gervits, MD; Joel Bumol, MD and Oladimeji Oki, MD

Introduction

Throughout the COVID-19 pandemic in the United States, disparities have been noted in infection, hospitalization, and death rates among racial, ethnic and socioeconomic groups. In New York City (NYC), these inequities were particularly stark. Deaths from COVID-19 among Black and Latinx patients were twice that of white patients.[1] This was compounded by lack of access to medical care in majority minority neighborhoods.[2] Access to COVID-19 testing also varied depending on zip code, with non-white and lower socioeconomic areas receiving fewer tests but having higher rates of positive results compared to white, affluent neighborhoods.[3]

Racial disparities have been noted in COVID vaccination as well, with communities of color being vaccinated at lower rates than white communities. This has largely been blamed on vaccine mistrust in these groups. However, lack of access is also a contributing factor due to missteps in vaccine rollout. A lack of access to strong, stable internet service or smartphones among lower socioeconomic groups has furthered vaccination inequity, since scheduling a vaccine appointment usually occurs online.[4] For the same reasons, communities of color have also experienced disparities in access to telemedicine care during the pandemic.[5]

Special populations, such as pregnant persons, those with opioid use disorder, and individuals with HIV, often experience the most extreme levels of systemic health inequity. We will discuss how they were, predictably, further marginalized during the COVID-19 crisis.

Care of Pregnant Patients

In the United States during the COVID-19 pandemic, Black and Latinx people represented a disproportionate number of COVID-related deaths among pregnant women, exacerbating the already disparate levels of pregnancy-related mortality among people of color compared to their white counterparts.[6] The pandemic has also disproportionately affected the finances and mental health of pregnant people of color, with Black pregnant women reporting worsened employment prospects than white pregnant women. They have also expressed more worries about getting quality prenatal care, having a positive delivery experience, and being able to obtain needed medications, food, and newborn care items.[7] Some Black patients have expressly noted that the racism and disrespect they have come to expect in the healthcare system worsened during the pandemic.[8] Meanwhile, people who have not wished to be pregnant have experienced barriers in access to contraception and abortion, caused by a decrease in office visits and many states trying to stop abortions by calling them non-essential services. This has been felt most acutely by women of color, as well as LGBTQ and low income persons.[9]

Our own experience in a largely Black and Latinx community in NYC paralleled that of the nation. In March, when COVID-19 hit New York hard, our outpatient services converted to mostly telemedicine overnight. However, much of prenatal and reproductive care still had to occur in person. Contraception and abortion counseling was done virtually prior to the office visit to limit the amount of time patients spent in clinic. Prenatal care visits alternated between tele-visits and in person visits, and we stopped providing group prenatal care. We shared our patients' frustrations with crackling phone lines and freezing video connections, and struggled to build rapport while social distancing in a mask, gown, gloves and face shield. The hospital limited laboring patients to one support person who had tested negative for COVID. Anxiety and depression rates were high among patients and providers. Some patients complained about tele-visits and their inability to bring partners to ultrasounds, while others feared to leave their homes for in-person care. Many lost their jobs and expressed concerns about finances. We struggled to find our patients COVID testing appointments and answers to their questions. Some patients got infected, though most had mild or no symptoms and delivered healthy babies. Many of their family members were less lucky. With the advent of the vaccines, and recent evidence that they are likely safe in pregnancy, there is hope that prenatal and reproductive care can return to normal.[10]

Care of Patients with Opioid Use Disorder

Patients with opioid use disorder (OUD) often experience a range of health disparities and stigma from the healthcare system, while at times also requiring enhanced attention for complex medical and psychosocial needs. Though medication for opioid use disorder (MOUD) can be a life-saving therapy, survey data suggests around 20% of OUD patients receive this treatment.[11] Black and Latinx patients with OUD are less likely to receive MOUD and more likely to die from an overdose than white patients.[12] Underlying this increased risk of an overdose death are other health inequities that disproportionately affect Black and Latinx communities, such as an increased risk of living below the poverty line, experiencing housing insecurity, and being uninsured. The COVID-19 pandemic and the many disruptions to both routine care and daily life that accompanied it resulted in significantly worse outcomes for patients with OUD. In May 2020, the number of overdose-related cardiac arrests more than doubled across the US compared to the same month in 2019.[13] Black and Latinx populations, in addition to those who are uninsured were disproportionately affected by these deaths.[14] Locally in NYC, overdose deaths increased at the beginning of 2020, with the highest rates of overdose death occurring in the Bronx.[15]

Multiple factors likely contributed to this increase in overdose deaths. Buprenorphine treatment programs and support structures had to be entirely re-evaluated during the pandemic.[16] Regarding buprenorphine treatment, the frequency of in-person visits and urine toxicology screening was dramatically reduced at our practices.[17] Stable patients would receive telemedicine check-in visits and urine toxicology screening was reduced to every few months. Though this strategy allowed for more social distancing during the peak of the COVID-19 surge, several patients were lost to follow-up or relapsed with opioid use, likely in part due to the disruption of the patient's daily routine and lack of enhanced clinical support. Furthermore, several patients lost their jobs at the height of the surge, creating even more social and economic instability for an already marginalized group. While our COVID-19 clinical protocols allowed for telemedicine intake visits and less initial follow-up for new patients undergoing a buprenorphine induction, the number of new patient referrals decreased substantially during 2020. The telemedicine medium was a barrier for some patients who lacked phone or internet access. The usual means of patient referrals, such as referrals from the inpatient setting, other local substance abuse treatment programs, and word of mouth among patients, were universally disrupted. Due to social distancing and encouraging patients to stay home during the NYC surge, many patients who might otherwise have been connected with an avenue for MOUD treatment were left alone at a vulnerable time. Though referrals have increased in 2021 in our practice setting, many patients suffering with OUD during the peak of the COVID-19 pandemic either saw their condition worsen, were unable to be connected with MOUD treatment, or unfortunately may have overdosed due to interruptions in routine care.

Care of Patients with HIV

People living with HIV (PLWH) are more likely to live in areas where a larger portion of residents live below the federal poverty level, do not have health insurance, have higher rates of unemployment, and lower median household incomes.[18] These determinants were all further stressed globally by the COVID-19 pandemic, which saw higher levels of financial insecurity, food insecurity and disrupted healthcare access. These same social determinants are also associated with an increased risk of COVID-19 infection, morbidity and mortality. For PLWH who contracted COVID-19, the morbidity and mortality data were initially conflicting. Early studies showed no difference in morbidity and mortality compared to the general population.[19,20] However, there is now evidence that PLWH who contracted COVID-19, especially those with a lower CD4 count, have poorer outcomes, including increased hospitalization, ICU admission, mechanical ventilation, and death.[21,22,23,24] Based on this knowledge, the CDC has listed HIV infection status as a risk factor for contracting severe COVID-19. Like COVID-19, HIV infection rates and outcomes have been subject to the same structural drivers of racism causing disparities in diagnosis and treatment, with Black and Latinx persons making up almost 80% of those living with HIV in New York City. One study showed that PLWH who contracted COVID-19 were more likely to be older, Black or Latinx, and to live in high poverty neighborhoods when compared to both the general PLWH NYC population and to the overall COVID-19 population in NYC.[24]

In our personal experience of treating PLWH during this pandemic, we have also seen higher rates of patients being lost to care, having positive viral loads (regardless of history of viral suppression), and increased feelings of depression and anxiety. This was likely further exacerbated as many of the healthcare providers who serve these communities (authors included) were redeployed to full time hospitalist duty during the spring of 2020, when NYC was serving as the epicenter for the COVID-19 pandemic in the USA. Patients had to adjust to new providers, a new telemedicine system, and lack of access to basic care such as lab work while dealing with the stress

continued on page 28

continued from page 27

and fear that uniquely affected disadvantaged communities. This contributed to many patients being lost to follow-up. While many of these patients have now re-engaged with care, many have also seen a significant change in their quality of life and health either due to personal sickness, social instability, or the worsening of their housing and income stability.

Prior to the pandemic, NYC had become closer than ever to achieving its goal of ending the HIV epidemic. The 2019 Surveillance Annual Report showed declines in new HIV diagnoses from 2018-2019, with overall new diagnoses rates down approximately 70% since the initiative began in 2001.[25] There has also been a decrease in estimated overall new HIV infections in NYC (a drop of 14%) from 2018 to 2019. Viral load suppression increased to 87% of those in care. During the initial COVID-19 pandemic, there was a substantial decrease in HIV testing. Furthermore, the reliance on phone and video conferencing may place patients in a difficult position of having to discuss sensitive issues in areas where others could overhear. Time and data will tell how the COVID-19 pandemic has affected progress on the HIV epidemic as routine healthcare returns to a city still recovering from the pandemic.

Conclusion

Systemic inequity, fueled by structural racism in our institutions, policies, and priorities have caused significant harm to BIPOC communities. These harms have resulted in an increased risk of morbidity and mortality as outlined above. While the above disparities preceded COVID-19, they have been further exacerbated by this pandemic. Populations that were already vulnerable/marginalized, such as pregnant patients (especially Black/Latinx), those with OUD, and PLWH, saw their health risks and outcomes worsen during this pandemic. And now, as administered vaccine doses increase and social distancing/masking guidelines are relaxed, these same communities are being left behind in the vaccination process. We call on the medical system specifically and society in general to acknowledge the intentional damage done to these communities through years of both harmful and racist policies and to be intentional about addressing the root causes. Any barriers that serve to support the disparities created by systemic racism must be identified, removed and/or prevented. This call includes more novel arenas such as telemedicine access, which is already showing the same access trends towards privileged populations. Many activists, community members, and health equity workers have spoken more eloquently on this topic than any of us could. They should be sought out, empowered, and compensated for taking on the task of beginning to reverse policies and practices of inequity. As family physicians, we are uniquely positioned to support our patients in these communities and advocate with them towards a more just health system.

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For additional endnotes and resources, see page 51.

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Overcoming Barriers to COVID-19
Vaccination for People with Developmental Disabilities

By Maria Kansas Devine MD, FAAFP, CPE

The coronavirus pandemic has highlighted disparities in healthcare access in many groups, none more so than in the population of individuals with intellectual and developmental disabilities. Obstacles have always included physical barriers to building access, comfortable exam rooms, absence of Hoyer mechanical lifts in primary and specialty practices, the need for increased support staff to assist in care, communication support, and the need for increased time and reimbursement for appointments, to name a few. Barriers to COVID- 19 vaccination for people with developmental disabilities are no exception and were largely not considered in the general vaccine roll out.

In the Capital District we have 18 Office of People with Developmental Disability (OPWDD) licensed service providers serving over 10,000 individuals with intellectual and developmental disabilities, 2,800 of whom live in group residences.[1] These individuals were not first identified as a priority group for COVID-19 vaccination, despite experiencing a high incidence of medical fragility and increased risk based on congregate settings. An additional 12,000 staff provide support services to these individuals in a variety of settings including residence, day program, respite and 'Without Walls' programming. Barriers to vaccination are numerous and include: issues of consent for individuals without capacity, individual ability to wear face covering for medical or behavioral reasons, transportation, ease of access to administrating facility, lack of access for wheelchair vans in drive-thru locations, lack of administrator familiarity with serving individuals with disabilities, inability of individuals to tolerate high stimulation environments, long wait times and comfort levels of affected families in attending large group settings, as well as lack of availability of vaccine in local and familiar family medicine practices.

Individuals with developmental disabilities in group homes suffered significant losses during the peak of the COVID infection and were significantly more likely to succumb to the disease. Many individuals have significant medical comorbidities and respiratory compromise which made individuals living in group homes much more likely to contract and to die from COVID-19. According to OPWDD statistics, as of May 12, 2021, 7,120 individuals in congregate settings tested positive for COVID virus, as well as 15,016 staff. Of these 667 individuals (9.3%) died,[1] compared to 1.7% in the general US population.[2] Complicating the matter was that these residential settings were not considered "healthcare facilities" and were therefore not prioritized for supplies of PPE.

continued on page 30

continued from page 29

Barriers to obtaining consent for individuals without capacity is often overlooked. While many of the individuals in congregate settings have loving involved family members, a significant number are without legal guardians. Acquiring the necessary informed consent was complicated and often required navigating the legal system.

Maneuvering mass sites, appointment systems and arranging transportation to non-medical sites provided even greater challenges. Many individuals could not navigate the physical challenge of getting into the sites from available parking- for example, The Times Union Center. The noise and physical stimuli were not tolerated by many. The required support for the immunization itself was not available or the skill of approach for special needs individuals, likewise not available. Many individuals could not tolerate mask wearing for any but the briefest of times and required separate space for individuals that could not mask or had sensory, emotional or behavioral support needs. The existing vaccine pods were not designed to accommodate these needs and limitations. In addition, attempts to accommodate these needs slowed the pace of vaccination in the mass sites. All of these factors created hardships in receiving vaccine at a drive-thru or larger vaccination location.

An Exercise in Community Collaboration

Collaboration is the buzz word of the day but in this case was genuinely accomplished. Albany Medical Center led the team that included the Center for Disability Services, New York State Industries for the Disabled (NYSID), OPWDD and affiliated agencies and the Department of Health, working together to identify best practices in serving this unique population. The Albany Medical Center hub was willing to designate the disability community as both a priority and a population in need. Local hospital hubs including Albany Med and St. Peter's Hospital redistributed the then scarce vaccine to the Center for Disability Services. NYSID coordinated rosters of eligible individuals, family and caregivers from local agencies and care providers. Consents were coordinated in advance with family members, and thanks to OPWDD's temporary authorization for Informed Consent Committees (ICCs) to provide informed consent for COVID-19 vaccines for individuals without legal guardians, the usual court process was avoided.[3] The Center for Disability Services reallocated staff and physical space for the vaccine clinic at our medical center. The space included a large open auditorium type space, as well as adjacent smaller spaces for individuals that could not mask or had intolerance to excess sound or stimulation. The space had direct access from handicapped accessible parking with no elevators, and was on a public transportation route. Some vaccine was delivered and administered by CFDS nursing staff directly to certified residences, particularly for individuals who could not tolerate public spaces. Center staff reached out directly to scheduling organizations to coordinate appointment times without requiring an on-line process. Clinics were scheduled and coordinated on short notice based on the sparse vaccine supply which was the situation at the time.

The results of our collaboration were proof of its efficacy. Over 3,200 individuals and their families and caregivers were fully vaccinated during this project. As of 4/19/21, 69.16% of Individuals in certified residences had received their first vaccine dose, compared to the statewide rate of 44.54%, and 51.82% of staff in certified residential settings had received their first dose, compared with the statewide rate of 31.99%. Individuals were served from Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington Counties.[4]

In conclusion, mass vaccination programs need to consider the special risks, needs and barriers for people with intellectual and developmental disabilities, as well as their families and caregivers. Barriers of consent, scheduling, physical access, accommodation of sensory and behavioral needs and alternatives to access for those unable to tolerate mask wear, should all be addressed in current and future mass vaccination programs. The need for specialized, sensitive and skilled staffing must likewise be included in any future plans. Collaboration across agencies and institutions made this endeavor possible and successful. It truly takes a village.

"Without this clinic, our son would have never been able to get this vaccine- you knew just what to do to make sure this happened."

– A client's father

Endnotes

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3. OPWDD Interim Guidance: Informed Consent committee for COVID-19 Vaccine, December 30, 2020
4. Data from NY Disability Advocates

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Geriatric Grief Management in the COVID-19 Pandemic: Barriers and Best Practices

By Maya Pandit, MPH and Rebecca McAteer Martin, MD

Introduction

The COVID-19 pandemic is well-documented to have disproportionately affected older adults, here defined as age ≥65, in terms of disease severity and mortality; however, it has also created unprecedented challenges in geriatric primary mental healthcare.[1] As communities have largely transitioned to virtual environments for professional engagement and personal socialization, older adults have generally faced social exclusion.[2] A survey in the United States conducted in March 2020 found that a mere 20% of adults older than 65 reported participation in online social gatherings.[3] The risk of decreased internet usage during the COVID-19 pandemic not only impacts older adults' socialization, but also precludes access to vital health information and telehealth resources.

The social isolation exacerbated by the pandemic has placed older adults at significant risk for mental health issues, increased suicide and substance abuse rates, and deterioration of cognitive and emotional health. Furthermore, elderly patients bear a disproportionate burden of loss owing to increased age-related mortality and morbidity risks. The sudden loss of loved ones in a context of pandemic-related social distancing restrictions has resulted in profound inability to grieve physically with the community, as well as a lack of traditional funeral services and other memorialization rituals, all of which have increased the risk for complicated, incomplete and prolonged grief.[4]

Without intervention, these forms of grief can exacerbate symptoms of loneliness, depression and anxiety, and pose significant long term physical and mental health risks.[5] Primary care providers face a significant challenge in recognizing, diagnosing and treating pertinent geriatric physical and mental health issues within this context.

Barriers to Geriatric Grief Management

Several barriers are known to impede older adults' access to optimal grief management and quality mental health care in the pandemic environment. Telemedicine unreadiness, physical isolation, insufficient provider availability in the face of exceedingly high mortality burden, and stigma toward bereavement care can contribute to under-recognition of grief among the geriatric population, as well as reducing their access to care when mental health and bereavement needs are identified. Pre-pandemic studies have revealed that older adults lag behind their younger counterparts in terms of internet usage, preferring in-person gatherings over those in the virtual setting.[6,7] Older adults are often not sufficiently prepared to utilize technology to access telemedicine services, whether due to disability,

continued on page 32

continued from page 31

or more generally, lack of experience with technology.[8] Additionally, physical isolation owing to widespread mandatory social distancing measures has deteriorated social connections for older adults already at increased baseline risk for loneliness-related depressive symptoms.[9] From a primary care standpoint, the COVID-19 pandemic has wrought a high burden of mortality, likely diverting physicians' attention from individual bereavement needs; this issue of workforce capacity may cause subtle yet potentially pathological forms of grief to go unrecognized in geriatric populations.[10] The pandemic has been noted to decrease access to psychiatric care in those with existing conditions.[11] Finally, many older adults perceive stigma towards bereavement care, which leads to lack of acknowledgment of their own grief, exacerbating their under-utilization of telehealth services and inhibiting family member engagement.[12]

Failure to identify and treat grief and its sequelae can result in dangerous immediate and long term outcomes. Older adults, already at increased risk of depression, anxiety, post-traumatic stress disorder, alcohol and substance misuse, and suicide, now face potential escalation of these mental health issues. Society-wide, and particularly among more vulnerable elderly populations, the current pandemic has wrought sustained levels of fearfulness, loss of community and social relationships due to strict social distancing regulations, financial instability as a result of the nation-wide economic downturn, and often the additional exacerbating factor of sudden, traumatic loss.[13,14] Pre-pandemic surveys revealed that 10.6% of adults over 65 reported unhealthy drinking habits, increased from previous years,[15] with increased alcohol intake as a documented potential reaction to grief.[16-18] This can cause or exacerbate chronic medical conditions if left unaddressed.[19] Bereavement in older adults has also been associated with weight loss, functional impairment, and increased risk of morbidity or mortality.[20,21] Many older adults face anticipatory grief, or distress regarding an expected loss, which has likely been enhanced by news media coverage of case surges and reported mortality rates. Additionally, complicated grief has been associated with long term psychological difficulties, increased medication use, higher disability rates, and impaired social functioning.[20] Most concerning, while it is not yet known precisely how suicide rates will be affected by the pandemic, deaths of despair are projected to increase, particularly in the period following the immediate pandemic crisis.[22]

Best Practices in Geriatric Grief Management

Family physicians are uniquely positioned to facilitate increased family and community support for bereaved elders, and interventions should be employed in the context of real or anticipated loss, in order to enhance older adults' support and aid in early detection of grief-related concerns. Primary care clinicians can prepare family members for anticipated deaths in order to decrease risk of post-death complicated grief.[23,24] Preparation for loss has proven benefit in reducing pre-loss and prolonged grief disorders,[25] specifically when incorporating social support and advanced care planning.

Grieving adults can experience a lack of family member support and understanding, manifested as an inability to discuss grief or dismissal of the topic altogether. Some have reported that while they desired social relationships, it often became difficult to maintain contact because of family members' negative reactions to the duration or severity of grief, and decreased communication post-loss.[26] Therefore, a family-centered care approach, in which family members are engaged in a collaborative ICU team for patient care, can be adapted for a pandemic environment to allow for greater communication and understanding among the physician, family members and grieving members.[27] Grief education is also vital for family members in order to support early recognition of bereavement distress in loved ones. Basic information presented in an accessible manner – for instance, insights into identifying grief, ways to support optimal self-care, and introductions to psychosocial interventions such as cognitive behavioral therapy – could be disseminated widely by primary care physicians to facilitate engagement with older adults.[28]

Family physicians also require training in bereavement pathology recognition, prevention and treatment that will benefit geriatric patients both peri- and post-pandemic. While general practitioners generally perceive grief management to be important and understand negative health consequences of bereavement, many still believe they are not equipped to deal with such issues. Surveyed providers report a wide variety of strategies on their current treatment of such patients, which are often based on older grief theories.[29-31] Therefore, primary

Grief Counseling Resources
https://omh.ny.gov/omhweb/grief/griefcounselingresourceguide.pdf **https://www.counseling.org/knowledge-center/mental-health-resources/grief-and-loss-resources** **https://nursingandhealth.asu.edu/sites/default/files/preparatory-grief.pdf** **https://www.aafp.org/afp/2002/0301/p883.html**
Grief Assessment Tools
https://www.hospicewaikato.org.nz/file/complicated-bereavement-risk-assessment-tool/open **https://psychology-tools.com/test/inventory-complicated-grief** **http://complicatedgrief.columbia.edu/wp-content/uploads/2016/05/BGQ.pdf**
Geriatric Technology Support Resources
https://hbr.org/2020/11/4-strategies-to-make-telehealth-work-for-elderly-patients **https://www.myfarewelling.com/article/how-to-plan-a-virtual-funeral-service#:~:text=A%20virtual%20funeral%20or%20celebration,memorialize%20their%20loved%20one%20digitally**

care physicians should be offered additional training opportunities in complicated grief therapy, adapted to suit phone or video call formats, with an emphasis on proactive outreach to the older adult community. Well established geriatric depression scales and screenings for physical conditions can be administered at greater frequency, and potentially with greater ease and efficiency, in a telehealth setting using mobile application assessment tools.[32-34] Specifically, the *Brief Grief Questionnaire* and *Inventory of Complicated Grief* were found to be useful tools for screening and management in one study of primary care behavioral health integration.[35]

Primary care practitioners can aid in creating healthy and accessible virtual environments for older adults. The pandemic has presented significant challenges due to limited physical mobility and increased social isolation, necessitating improved telemedicine access and training for older adults to enhance comfort with virtual engagement. At a minimum, primary care practitioners should utilize more geriatric-friendly forms of telemedicine, such as phone consultations.[36] In the context of larger societal observances, the pandemic has prevented many from taking part in traditional funeral and memorial rituals, which play a crucial role in the grief cycle.[37] Providing patients with resources for virtual funeral services and commemoration programs can often aid the bereaved in finding closure and gaining social support.[38] There may also be benefit in supporting patients and their family members to create new or altered rituals within the constraints of the pandemic environment, modifications which can continue to be incorporated post-pandemic.[37] Additionally, at the policy level, organizations representing the interests of primary care physicians should advocate for reimbursement of digital service costs, increased virtual-platform availability for vulnerable groups, and virtual-interface training opportunities for older adults where they would be most readily accessible to this population.[39]

Conclusion

The COVID-19 pandemic has revealed numerous gaps in geriatric grief management, including bereavement under-recognition and management. Telemedicine unreadiness, increased social isolation, workforce capacity issues, and perceived stigma around mental health and bereavement in this population are thought to be contributing factors. As a result, mental health issues in this population – both pre-existing and those exacerbated by loss – are of great concern, and enhanced attention is warranted to sufficiently address them utilizing effective practices identified in the literature. Primary care physicians can have a powerful role in mobilizing and coordinating family support for elderly patients identified as being at increased risk for mental health challenges or complicated responses to grief. Physician workforce training should be made available to support physician comfort with both the identification and management of bereavement-related mental health concerns in this population. Efforts are also called for at the level of community practice as well as policy advocacy to improve virtual platform accessibility for this at-risk population. Even in a post-pandemic environment, best practices applied and adapted during the COVID-19 era will arguably continue to support optimal geriatric bereavement care moving forward.

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continued on page 34

continued from page 33

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Grief Education in Medical School: Insights from the COVID-19 Pandemic

By Maya Pandit, MPH and Rebecca McAteer Martin, MD

Introduction

The COVID-19 pandemic has led to significant challenges and changes in medical education. In response to strict social distancing guidelines, much of medical school training has transitioned to virtual formats, incorporating online clinical experiences, patient interactions, lectures, and case-based discussions.[1-3] Amidst these widespread changes, discussions have emerged regarding pandemic preparedness curricula for medical students, including topics such as disaster response, ethical decision making, and the value of multidisciplinary collaboration.[4] These discussions have also emphasized the importance of preparation for adverse mental health sequelae, specifically those of acute situational distress, post-traumatic stress disorder, and anxiety syndromes.[5] In order for future physicians to provide quality patient care and adequately attend to their own mental health needs, it is essential that medical education formally and adequately prepare student doctors to confront, understand, and seek support for their own emotional and psychological responses to loss.

The Need for Grief Training in Medical Education

The COVID-19 pandemic resulted in an unusually high death toll in a brief period of time, negatively influencing the mental health of frontline workers in particular.[6] The fast-paced pandemic environment of uncertainty and heightened anxiety has fueled maladaptive responses to loss, including disenfranchised grief and anticipatory grief. In pre-pandemic studies, these reactions to loss have been shown to adversely affect clinical decision making, individualized patient care, and physicians' mental health.[7-9] While there have been strides in medical education to provide students with opportunities to discuss grief and train in proper bereavement care for patients, grief coping skills for medical students remains a largely under-emphasized area within medical education. Many studies have focused on student education for providing grief training to patients. This education has often taken the form of short, optional modules or seminars, and has not sufficiently incorporated personal experience.[10] Medical students perceive a lack of skills needed to sufficiently address grief[11-12] and existing opportunities have not adequately enabled students to incorporate their own awareness and experiences. Evidence has shown that such opportunities for structured reflection are beneficial to students when incorporated into end-of-life care education.[13] Research from across medical subspecialties, including psychiatry and pediatrics, has revealed that physicians frequently feel unprepared to address the wide spectrum of grief presentations and report lacking the necessary skills in communicating with dying patients and their family members.[14-16] The general dearth of recent literature in grief-coping education, and the pre-pandemic evidence of inadequate skill-building to deal with loss, necessitate an exploration of the potential negative impacts of physician grief on patient care and consequent opportunities for intervention in medical education.

Disenfranchised grief, an unacknowledged reaction to loss, has been prevalent during the COVID-19 era, characterized by a high rate of death that resulted in decreased personalized attention to each

continued on page 36

continued from page 35

death.[17] This has led to suboptimal bereavement care for family members, and was also considered a risk factor for physician burnout, a phenomenon well-documented in the pre-pandemic literature. The disenfranchisement of physician grief can be attributed, in part, to the hierarchical organizational structures inherent to many medical practice models, in which physicians may be concerned about the negative impact on career progression if vulnerability to loss is manifested, and further compounded in physicians who lack close peers in whom to confide.[18] The consequences of physician burnout, particularly the subtypes of emotional exhaustion and depersonalization, result in significant negative impacts on physician wellbeing, including an increased risk for suicide and substance abuse, increased medical errors, negative patient outcomes, and longer patient recovery periods.[19]

Anticipatory grief, too, has been widely prevalent during the uncertainty of the COVID-19 pandemic environment, and swiftly changing circumstances can lead to symptoms of acute distress and post-traumatic stress disorder[20] that fuel existing physician anxiety surrounding conversations about death and bereavement, and impede quality end-of-life care. For instance, research has shown that physicians with higher death anxiety had more difficulty explaining a terminal prognosis to a patient, engaging family members, and collaborating with other professionals.[21] Physicians with increased fear about death also demonstrate suboptimal decision-making skills and question their own clinical choices, often leading to doubt and guilt after a patient's death, avoidant behaviors, and distancing from death-related topics, which can lead to decreased empathic responses in patient care.[21] Given the adverse effects on patient care and physicians' emotional health, pandemic preparedness curricula and grief training would be enhanced by ensuring that attention is paid to addressing a range of complex grief responses besetting physicians in the wake of professional-setting losses.

Approaches to Grief Training in Medical Education

In order to enhance the effectiveness of grief-coping training for students, exposure to topics of death, dying, and grief should be included earlier in medical school, and incorporated in an integrated, longitudinal manner. There are few research studies that focus on preclinical medical students' reactions to death and grief, and those that do largely emphasize the dearth of training around proper coping strategies. While the anatomy lab cadaveric dissection is often a medical student's most significant preclinical transitory experience, it has also been associated with emotional stress, and can provide an opportunity to incorporate discussion on the humanistic aspects of medicine.[22] Exploratory studies have argued for the incorporation of conversations on topics related to death, grief and loss both before and during the course, while also connecting these to students' lived personal experience, in order to reduce feelings of depersonalization, encourage balance between emotional empathy and detachment, and establish an appropriate professional distance from loss.[22-23] Studies have revealed writing exercises to be an effective method of recognizing student responses to loss and grief, while simultaneously providing educators with valuable first-hand insights into this particular area of educational needs on an individualized level.[24]

During the clinical years, integration of grief training into relevant specialties can aid in a multidisciplinary understanding of physicians' response to grief. Physicians and trainees working with pediatric cancer patients have reported a range of negative feelings in response to patient death, including sadness, guilt, feelings of failure, and helplessness, which had impact beyond the workplace with reported feelings of disconnection from loved ones and irritability at home.[25] Pediatric oncologists have reported that discomfort with topics of death was a barrier to providing quality end-of-life care, but also that short workshops were insufficient in creating lasting change, indicating a need for more intensive approach to training in palliative care topics.[26] Studies have also revealed differences in grief reactions of clinical oncologists based on gender, with females reporting higher levels of emotional distress and burnout, suggesting an important role for individually-tailored education and special consideration of risk factors for complex grief reactions.[27]

While medical students addressing end-of-life care needs during their internal medicine clerkships benefitted from pre-clinical didactics, many reported greater value of clinical experiences in which their teams acknowledged a patient death and the resultant emotional reactions of team members.[28] Attending and resident physicians, whether in a formal mentoring relationship or not, should be reminded that by virtue of their prominent positions as clinical role-models on teaching service care teams, they play a pivotal role in early medical trainees' perceptions of death and appropriate responses to loss. This suggests that open acknowledgement, healthy communication, and creation of an appropriate space for vulnerability should be cultivated in mentoring relationships and formally supported at an institutional level throughout the process of professional development.

Grief Counseling Resources
https://omh.ny.gov/omhweb/grief/griefcounselingresourceguide.pdf **https://www.counseling.org/knowledge-center/mental-health-resources/grief-and-loss-resources**
Medical Clinician/ Trainee Wellness Resources
https://students-residents.aamc.org/medical-student-well-being/medical-student-well-being **https://www.bereavemed.com/** **https://rishiprograms.org/healers-art/** **https://nam.edu/initiatives/clinician-resilience-and-well-being/clinician-well-being-resources-during-covid-19/** **https://www.ama-assn.org/delivering-care/public-health/6-ways-address-physician-stress-during-covid-19-pandemic** **https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment**

As medical education continues to evolve in the wake of the COVID-19 pandemic, it is essential that grief coping skills for physicians-in-training be prioritized in curricular development. Several learning methods have been associated with improved patient and physician wellbeing outcomes, including providing opportunities for self-reflection, offering resources about grief and end-of-life care, observing memorial services, and facilitating small group discussions.[13,29] One study focusing on effects of a grief training intervention for internal medicine residents found that providers were more likely to engage in appropriate grief-support behaviors, following an educational curriculum delivered as two 120-minute sessions to a group of 40 residents. Results from pre- and post-intervention self-report surveys demonstrated a greater propensity of residents to engage in appropriate grief support behaviors following the training, including enhanced anticipatory guidance around the grieving process (pre: 42% vs. post: 57%), increased frequency of follow-up after the loss (25% vs. 50%), exploring the context surrounding loss (47% vs. 63%), offering physical touch (64% vs. 73%), and providing counseling services (42% vs. 83%). Respondents also indicated that they were more likely to support involvement of patients' families and support networks to aid in coping with their loss (72% vs. 87%), as well as sensing an overall deeper humanistic connection around the loss, including the sharing of their own/ personal loss experiences (6% vs. 17%).[30]

Medical school faculty can consider incorporating similar workshops for building grief-coping skills, as well as additional training in optimal grief support for patients. A grief-coping skills course, for instance, could take the form of a series of large group lectures on recognizing signs of pathological grief and learning how to engage helpful grief-coping mechanisms, followed by facilitated small group sessions that allow students to reflect upon personal experiences and share with their peers, thus implementing the practice of debriefing and creation of appropriate spaces of vulnerability for healthy grief processing. Such a course could also include insights from more experienced clinicians on how one might show vulnerability and personally connect with colleagues and patients in a professional manner while being mindful of the environment and context in which personal stories are expressed.

Conclusion

Future physicians are called to fulfill their role as healers through the provision of quality patient care, while at the same time adequately attending to their own mental health needs. It is imperative that medical education prepare student doctors to confront, understand, and seek support for their own emotional and psychological responses to loss. This can be best accomplished by building evidence-based opportunities into the medical school curriculum that enable individual self-reflection and collaborative peer- and mentor-facilitated processing of these experiences.

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For additional endnotes and resources, see page 52.

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America's Pandemics:
Family Doctors Were Always There

By Thomas C. Rosenthal, MD

Just like twenty-first century family doctors facing the coronavirus pandemic, village doctors of the nineteenth century faced unknowns that stunned 'modern' medicine and overwhelmed politicians, businesses, and patients.

Dr. Benjamin Rush promoted bleeding and purging as a cure for yellow fever that killed ten percent of Philadelphians in a 1793 pandemic. He claimed it was caused by miasma rising off of a spoiled coffee shipment.[1] Besides raising oxygen levels by exploding gunpowder in city streets, Rush recommended drinking chicken broth, sprinkling vinegar or camphor around living quarters, and avoiding night air and alcohol. Dr. Adam Kuhn advised patients to drink strong lemonade or weak wine and bathe in cold water twice a day. Banks closed and clergy encouraged the faithful to gather. In his notes Rush notices an abundance of mosquitos that disappeared, along with the pandemic, at the first frost. But it would be 1880 before Walter Reed proved the *Aedes aegypti* mosquito carried yellow fever. Rush treated yellow fever with calomel (mercury and rhubarb), a potent cathartic meant to cleanse poisons from the bowels, and repeated bloodletting of 8-10 ounces until the patient fainted or symptoms subsided. Salivation, according to Rush, indicated recovery was near, though more likely it was a sign of mercury poisoning. His remedies were criticized as heroic, but Rush claimed to cure 99 out of 100 patients.

In 1843, when residents of upstate New York's North Boston began dying, the village consulted a 'doctor' of Thomsonian botanicals. When ten people died in the first few days, they turned to a licensed graduate physician. He recognized the affliction as typhoid and requested the assistance of a newly appointed public health officer from Buffalo, Dr. Austin Flint, best known today for his description of heart sounds. Upon his arrival Flint conducted an autopsy on a child and confirmed inflamed groups of lymph nodes around the intestines (Peyers patches) that William Gerhard found so characteristic of typhoid in Philadelphia.

Flint visited every home and mapped every case. The first case was a young man from Warwick, Massachusetts who arrived in the village by stagecoach too ill to continue. Two days later he died at the Fuller Tavern. Over the next few weeks, fever struck seven of ten families living in North Boston, including five of seven Fuller family members between ages 3 and 23. Other families with typhoid either frequented the Fuller Tavern, obtained water from the Fuller well, or used the community latrine. Two families with their own water supply and latrines were unaffected. The Fullers had a long-standing feud with the Stearns family and accused them of poisoning the tavern's well. After Flint tested the water, finding it clean and uncontaminated, the Stearns sued for slander and won a $100 settlement.

A Warwick clergyman reported the young man was well when he left Massachusetts, but Warwick had several typhoid cases. All Boston, NY patients had contact with an ill person or their emissions, but the intemperate, those consuming a poor diet, and those under 25 were most likely to die. Flint concluded that the typhoid agent was a typhoid specific miasma arising from the discharges of sick patients.

Flint eventually published three scientific papers about North Boston. The first, in the 1845 *American Journal of the Medical Sciences* with later reports in *Clinical Reports in Continued Fever* in 1855, and the last as a paper presented to the American Public Health Association in 1873. Each successive paper made corrections based on expanding knowledge about contagions.[2]

The New York Medical Society's vaccine campaign using Jenner's cowpox in the second quarter of the nineteenth century greatly reduced the incidence of smallpox, but quarantine remained society's main public health strategy. Neighborhood fear and speculation, not science, enforced it. The New York Marine Hospital (indecorously called the 'Quarantine' Hospital) opened in 1799 on Staten Island. During the 1800s, as many as eight thousand immigrants a year, suspected of harboring yellow fever, measles, typhoid, smallpox, cholera, or typhus, were isolated for as long as six months at Quarantine. In September of 1858 a mob, fearful of the Quarantine's miasma, set the hospital ablaze.[3]

It was cholera that finally matured American doctors' understanding of pandemics, contagions, and bacteria beginning with the cholera epidemic of 1832. Long known in Asia, cholera spread across Europe and entered New York's back door, traveling down the Saint Lawrence River from Montreal, to Lake Champlain; then splitting at the Hudson River Valley to course along the Erie Canal to Buffalo and points west. New York's governor, Enos Throop, proclaimed that, "an infinitely wise and just God has seen fit to employ pestilence as one means of scourging the human race for its sins."

The New York Medical Society published alerts and the state legislature empowered municipalities to establish health boards. Village doctors generally supported the boards, but held to the conviction that any water a horse would drink was safe for humans. When cholera failed to return in 1834, the boards were dissolved.

Many village doctors joined with their patients who reasoned patient discharges carried a cholera contagion. This despite one medical journal claiming the lower incidence of cholera at higher altitudes proved cholera was spread by a heavier than air miasma; or an AMA special committee concluding that cholera was not contagious. Rush's heroic methods were finally challenged when Philadelphia's health board statistics found patients treated with homeopathic dilutions survived at higher rates than those who were bled and purged. Still, when cholera returned in 1849, New York's hospitals followed 1832 protocols recommending hourly administrations of calomel and opium. Thirty percent of hospitalized patients died.[4]

Just like 2020's coronavirus pandemic, magazines and itinerate salesmen hawked specious preventives. Nineteenth century general stores sold camphor amulets and villages burned pitch to neutralize cholera's miasmic taint. Chicago's Dr. Byrd sold millions of sulfur pills that he said eliminated the ozone causing cholera, and a whiskered Old Jacob Townsend advertised sarsaparilla. Homeopathic medical journals bragged that science had proven one of their dilutions particularly effective. Many still blamed poverty, though village doctors knew cholera struck poor and wealthy indiscriminately. Many doctors died, and those who survived were accused of taking tonics they kept secret from their patients. This time the pandemic smoldered across New York for five years. Tubercular consumption killed more people, but the sudden death of cholera terrorized everyone.

Mary Abigail "Abbie" Powers Fillmore, the daughter of President Millard and Abigail Fillmore, was arguably more popular than her father. College educated and conversant in five languages, Abbie taught in Buffalo's public schools until Zachary Taylor's death elevated her father to the presidency. In the White House she was known for impromptu performances on the piano, harp, and guitar and was the darling of newspapers around the world. When antipathy for the Fugitive Slave Act denied Fillmore the Whig nomination in 1852, the family returned to Buffalo in 1853.

On July 25, 1854, the twenty-two-year-old Abbie boarded the afternoon stagecoach intent on helping her grandfather, Nathaniel Fillmore and his second wife Eunice, settle into a new home next to Jabez Allen, MD, an East Aurora village doctor. Abbie purchased peppermints at the Allen drugstore to settle an upset stomach but awoke before midnight with diarrhea and vomiting. Shortly after midnight her grandfather sought Dr. Allen's attendance.

Abbie's suffering was acute. Retching, rice water diarrhea and painful muscle cramps left little doubt she was in the grasp of cholera. A messenger was dispatched to Buffalo to summon the President. Every hour Dr. Allen administered repeated doses of bicarbonate of soda and laudanum and refreshed a sinapism of powdered black mustard over her liver area.

Former President Fillmore arrived mid-morning; Abbie passed at 11 am on Wednesday July 26, 1854. Her grave in the family plot in Buffalo's Forest Lawn Cemetery is marked only with her initials. Dr. Allen sent no bill. Some months later, Millard Fillmore presented the Allens with a silver teapot.

John Snow's landmark treatise titled *On the Mode of Communication of Cholera* was published in 1855.[5] Snow referenced Flint's paper about the typhoid epidemic in North Boston, NY and mapped cholera around several London wells proving that water exposed to human discharges carried cholera. His maps also showed cholera traveled from city to city along the path of human trade, never spreading faster than people travel. Snow shifted blame from victim behavior to an external agent, though he remained unsure if the contagion was a chemical poison or a living germ. Fear may have inspired the common intuition for quarantine, now the learned opinion of the medical profession was catching up.

Measles killed more soldiers, but cholera plagued troops throughout the Civil War and in their hometowns following the war. By 1866, New York City's Council on Hygiene proved that sanitary measures limited cholera's impact. The City of Buffalo, and nearly every village in the state, adopted New York City's programs, curtailed free ranging pigs and separated water supplies from human discharges. In 1883, Robert Koch identified the *Vibrio cholerae* bacillus.

In 2019-20 it took only weeks for the world to learn about a dangerous pandemic and that it was a coronavirus. Only a year later vaccines began protecting communities. Science changed the impact of pandemics, but it remains the purview of the family doctor to explain the science to our ever-mutable nation's citizenry.

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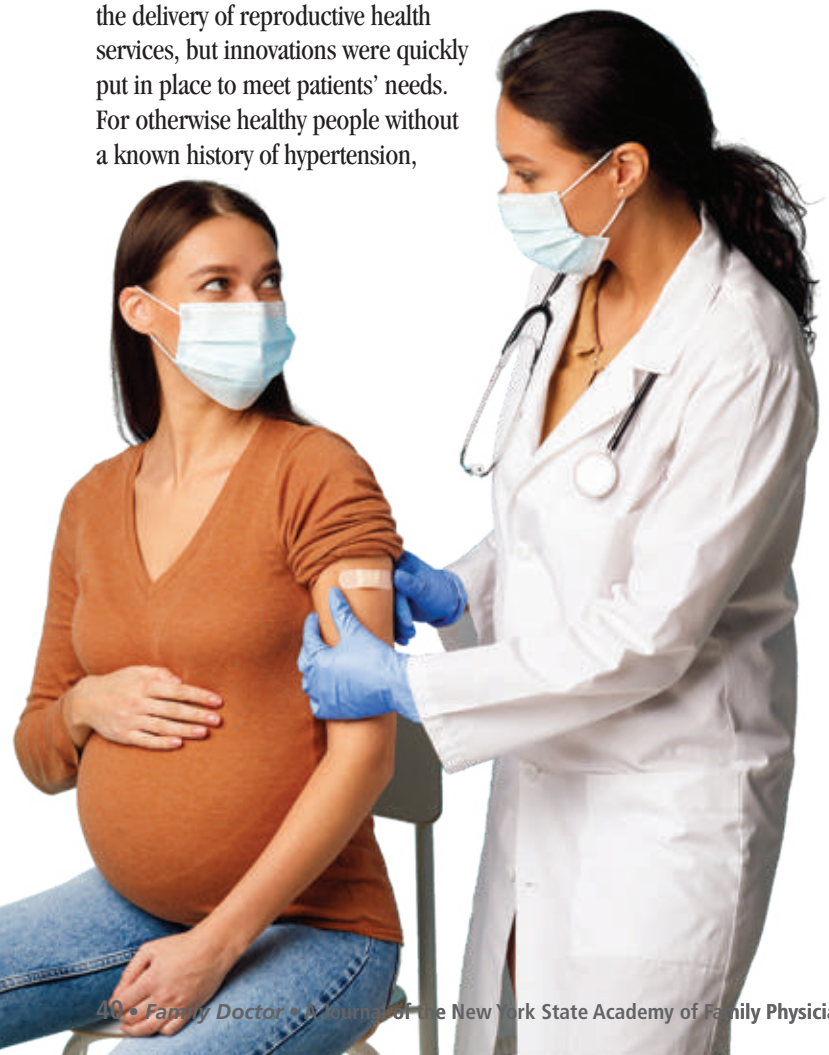
Reproductive Health Care in the Time of COVID: Changes We Can Take with Us

By Debby Glupczynski, MD; Ana Garcia, DO and Linda Prine MD, FAAFP

To date, there have been over 164 million cases of COVID-19, with over 3.4 million deaths-and these numbers continue to rise. New York City was an early epicenter, and the onset of the pandemic disrupted every sector of life; few more so than health care. Medical offices had to pivot quickly to telehealth and provide as much care as possible while limiting clinicians' and patients' need to travel. In the field of reproductive health care, family practice clinicians examined the evidence to determine when office visits were truly needed or when care could be given via telephone or video. This article will summarize the changes made, the evidence to support them and explain the areas where in person care remained essential.[1,2]

Navigating the complexities of private and confidential care when individuals, especially teens, were quarantining with their families in close quarters, emerged early on as one of the most challenging aspects of providing virtual comprehensive reproductive care.[3] As teens are considered emancipated by New York State when it comes to matters of sexual and reproductive health, providing confidential care to them remained a priority.

In the early months of the pandemic, many clinical sites shut down for in-person care and switched to virtual or telehealth. This impacted the delivery of reproductive health services, but innovations were quickly put in place to meet patients' needs. For otherwise healthy people without a known history of hypertension, migraine with aura, or thromboembolic events, estrogen containing methods like the pill, patch or ring could be safely offered via telehealth without an office visit. Prerequisites for prescriptions-like cervical cancer screening or blood pressure checks-proved unnecessary. Pap smears should not be linked to contraceptive care in general, and with no history of high blood pressure it would be very rare for a reproductive age person to suddenly develop it. The prescription could then be sent to the pharmacy with refills for one year. If a concern arose about blood pressure, patients were instructed to check their blood pressure at home or at the nearest pharmacy.



For contraceptive methods that previously required in-person visits, creative solutions were developed, like video visit instruction on self-administration of subcutaneous medroxyprogesterone, and online visual resources instructing on intrauterine device self-removal.[4] For patients desiring a new intrauterine device/subdermal contraceptive implant or needing replacement of an expiring device, a patient centered approach was taken, making sure that it was actually time to replace the device, offering bridging methods that wouldn't require an office visit, etc. This could be done via telehealth but ultimately, some offices remained open for in-person care so that patients could receive their desired contraceptive method. Reproductive health care is essential, basic health care and the pandemic didn't change this.

Optimizing the provision of immediate postpartum contraception before hospital discharge proved an essential best practice as well. Hormonal and copper IUDs, subdermal contraceptive implants and medroxyprogesterone injections can all be safely used in the immediate post-partum period.[5] This minimized the need to travel for contraception after hospital discharge.

Even prior to the pandemic, many people had limited access to abortion care services. In 25 states, based on data from 2014, more than half of women lived in a county without a clinic providing abortion care.[6,7] With the declaration of a public health emergency due to COVID, states like Ohio and Texas declared abortion care elective and closed clinics providing this essential care. Medication abortion, either through a provider via telemedicine or self-sourced, was a highly desired option for many people facing an unintended pregnancy in the midst of a pandemic.

Based on evidence showing that medication abortion can be safely offered without a required ultrasound to people with a certain last menstrual period and no risk factors for ectopic pregnancy, clinics and providers used "no test" telemedicine protocols for medication abortion and follow up. Patients only had to present in person to pick up the medications (mifepristone and misoprostol), and complete Rh testing if indicated.[8,9,10] For a short period, mailing abortion pills was legal during the pandemic, and has again become legal as of April 17th, 2021. Online resources and websites are available to help find clinicians willing to mail pills and to address questions that may arise

while having a self-managed medication abortion. This innovation was based on prior research, but probably would not have been implemented so quickly if not for the pandemic. Ongoing research continues to support this approach as safe and satisfying to patients.[11]

During the pandemic, women/ patients still had miscarriages. Determining this diagnosis from a call with a patient who is pregnant and bleeding, without an office visit was challenging. The first question is whether an ultrasound has been done to establish that the pregnancy is in the uterus. If not, an in-office ultrasound or one at a radiology site closer to her/ their home needed to be quickly obtained. In New York City, no one wanted to go to the ER at the height of the pandemic, as the ERs were overflowing with patients with Covid. If the patient had already been seen prior with a confirmed intrauterine pregnancy and was bleeding, serial quantitative hCG measurements at a lab near her/ their home could be ordered.[12] If the lab results established the diagnosis of miscarriage, the choice of expectant management or medication management with mifepristone and misoprostol could be offered. Now that some of the FDA restrictions on mifepristone have been lifted, these medications can be ordered through mail order pharmacies and the patient does not have to leave home to obtain them.

When patients did not have a pregnancy visible on the ultrasound, the algorithm in the AFP article on ectopic management can be followed by drawing serial quantitative hCG measurements at a lab close to the patient's home.[13] In consultation with OB back-up, patients who met the criteria can be treated with methotrexate by injection, in the office rather than in an ER. These ways of treating miscarriage and ectopic pregnancies allow more patients to avoid hospital ERs and can remain a patient centered approach.

On another front, the questions and physical exams associated with reproductive health care services can be very triggering for people who have experienced trauma and have traditionally posed a significant barrier to seeking out in-person care. Virtual care may be an easier point of entry into the health care system for someone who has experienced trauma. They may feel more comfortable seeking care from a space they feel safe in rather than having to enter a medical office. The pandemic revealed some of these preferences as some patients became more willing to access care once in-office appointments and exams were no longer required. The pandemic taught clinicians that continuing to offer people different ways of seeking care allows them to choose what they feel most comfortable with. In this way, patient centered and trauma informed care became enhanced.

In conclusion, many patient-friendly changes were rapidly implemented during the pandemic that benefitted patients. Implementing new prescriptions for contraceptives without an office visit was and continues to be appreciated. Getting birth control refills for 12 months at a time was more convenient. Using medroxyprogesterone by subcutaneous injection was preferred by many. Taking care of wanted pregnancies with complications or unwanted pregnancies with as little testing as possible allowed for patient centered care and decreased Covid exposures. Ensuring access to comprehensive reproductive health care during the COVID-19 pandemic established new avenues to empower and strengthen the patient's autonomy in their health care decision making. Rather than looking to the end of the pandemic as a "return to normal," it is possible to look forward to a new and better normal that centers patients' needs more definitively.

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An Aggressive Approach to Outpatient COVID-19 Management with System Wide Benefits in Relation to Hospitalization and Death[1]

By Lazarus Gehring, MD; Caitlyn Burford, MD; Kimberly DeSantis, MD; Michael Federico, DO; and Eric Lorraine, DO

This work highlights a case series of 1146 COVID-19 positive patients and the approach of an innovative group of family physicians in Broome County, NY during the COVID surge period of October 5, 2020 through February 28, 2021.

Introduction

After the tempestuous real-time introduction to the COVID-19 pandemic in the spring of 2020, we were convulsed with the reality of our weak, defanged, and defenseless position as family physicians. We saw many of our patients die from COVID-19 and many more of our patients suffer significant morbidity and mortality resulting from delayed or absent care. Those observations were the germinating seeds for a new approach to tackling the disease caused by this novel coronavirus. We could do video visits, and in fact, we started to do them on day one of SARS-CoV-2's assault on Broome County, New York. What we were missing was rapid, accurate, plentiful testing for COVID-19 suspects and a safe place to evaluate these patients – live and in the flesh. We simply needed to experience up close and personal this novel disease in order to observe its chimerical aspects. Seeing patients on a video and then sending them for testing somewhere else with very long result times was causing difficulties with timely treatment and appropriate quarantine measures. This is the story of how one group of family doctors in the Southern Tier of New York bonded together to create an office with a mindset steeped in pandemic history, in rapidly changing disease science, in safety amidst danger, and in esprit de corps with our staff to serve our community.

Our office, Endwell Family Physicians, sits neatly in the southern portion of Broome County. We have over 35,000 patients and see just over 400 outpatients daily. Additionally – we round on our patients when they are hospitalized. There are ten managing partners, all board-certified family physicians, and 115 staff members. During the surge period (for the purpose of this paper, October 5th 2020 through February 28, 2021) our county was the 9th and 10th most COVID-19 burdened of the 62 counties in New York for cases and deaths per 100,000 people respectively.[2] After being thoroughly mocked by nature in the spring of 2020, we took advantage of the relative lull in COVID cases during the summer to formulate a plan for what was sure to be a taxing fall and winter.

Preparation

Our preparations began and ended with rich, frequent communication across all facets of our practice. Besides a COVID team of physicians which met daily to discuss office safety, PPE needs, supply chain requirements, SARS-CoV-2 testing capabilities, and office/hospital patient flow, we utilized our dedicated, thoughtful, and knowledgeable staff leaders to foster an office brimming with nervous energy for the ensuing pandemic season. Our goal was to create the only known COVID "respiratory" clinic right in our office offering evaluation, testing, and treatment in a safe fashion.

Besides daily physician meetings, we had biweekly staff meetings packed with COVID data, local hospital informatics, local disease trends, and evolving safety measures. We procured PPE along with rapid PCR and antigen testing. We educated clinic workers in proper donning and doffing of PPE, and educated our staff on SARS-CoV-2 testing. We re-engineered office flow for night COVID clinics through a separate entrance to our office adding another feature to our daily practice. We invested in MERV-13 air filtration for our entire office as well as the optically magnificent gun-like electrostatic sprayer to cleanse all of our patient areas.[3,4,5,6,7] We had staff cyber-linked to work from home to cut down on crowding. We staggered break times and cleared out more common space for our staff to eat meals. We put our beloved co-workers in N-95's along with goggles and/or face shields in early September while role playing COVID clinic flow to maintain safety, efficiency, and timely COVID result communication.[8,9] We collectively learned "COVID time" which means: what is good for today will surely change by the end of the week! In short, we had become COVID ready.

Patient Flow

Patient flow is an exceedingly important aspect of COVID-19 care. How a patient was scheduled, evaluated, tested, and triaged from our office was the source of much work and subsequent re-evaluation. The overarching principle was and is safety for everyone.

The process started with a call to our office concerning COVID-19 symptoms. The patient would then be given an appointment within 24 hours and instructed to call a specific phone number when they arrived at our clinic. The patient was directed by our staff and by signage to our clinic entry, where they were met by a "runner" in full PPE who escorted them to an exam room. The physician, the only person that the patient had any real contact with, would perform vital signs, an examination, SARS-CoV-2 testing and bag the swabbed sample. The runner would bring the swab to the lab tester to commence testing and escort the patient back to the exit door unless the physician deemed it necessary for a sick individual to stay for oxygen or other needs. The test outcome was then communicated by a "caller" who gave the patient their results, as well as any advice provided by the physician. Often the physician would call positive patients with their result and suggestions. Typically, one physician would see 20 or more well-vetted patients for COVID-19 symptoms per night. Complete donning and doffing of PPE were done after each patient in a special room designed for such. Room cleaning was completed after each patient.

Testing

We knew that testing accuracy hinged upon analyzing high pre-test probability individuals, that is, symptomatic patients during a surge

period.[10,11,12] Although we would have liked to commence our efforts sooner than October 5th, that was the earliest date we could go live as we were awaiting the arrival of Abbott Lab's ID Now rapid PCR testing kits which we had ordered two months before. We aggressively hazed our Abbott representatives into submission – at least that is what it felt like! As it turned out, October 5th was the beginning of our area's surge which lasted into early March of this year. As our COVID clinics continued we added Quidel/Sofia's rapid antigen testing capabilities. We used the different tests based on patient presentation and test availability. Our clinics ran Monday through Friday from 5:30 pm until 9pm.

History

Our "COVID team" became a group of physicians versed in pandemic history sharing a mindset toward future technologies and treatments. Educating ourselves on both previous pandemic pitfalls and real time information allowed us to avoid being trapped into ineffectual treatments designed for other diseases.[13] Our study taught us that disease-specific treatments would likely be the most useful.

Having COVID-educated clinicians armed with clinical acumen, using monoclonal antibodies for treatment, and proffering the use of effective vaccines was our goal.[14,15,16] We set up a COVID at Home program and pressured our local hospitals to expedite monoclonal antibodies for our use. This dove-tailed nicely with our established presence as hospital physicians and with our already established COVID follow-up video visit program for those patients who were not seriously ill. See Figure 1. We did try to become an infusion center for the purpose of giving mAb's during our clinics, but ran into numerous obstacles with NYSDOH. We became certified in lung ultrasound which was utilized in all venues (hospital, COVID at Home, and in office clinics).[17] Also, our office had been involved in Pfizer's mRNA vaccine phase III study since July 2020 which helped with staff vaccine education and support.

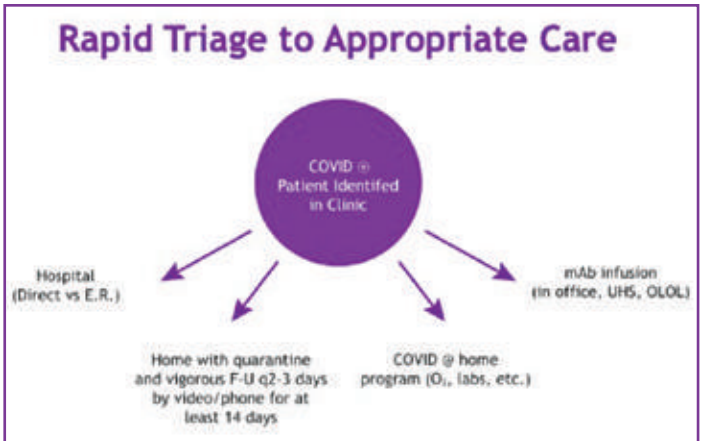

Figure 1: What Happens When Diagnosed with COVID-19. Note UHS = United Health Services Hospital's Infusion Center, OLOL = Our Lady of Lourdes Hospital Infusion Center

One of the benefits to our patients that we immediately noticed was that we could result and triage high risk patients who qualified for mAb infusion rapidly, often keeping the time from test to infusion completion to the same day if they were tested in our office. (See Figure 2, page 44) When we were relying on testing outside of our office, multiple delays in reporting could move a high-risk patient beyond the window of opportunity for infusion. Another benefit to our patients was the ability to diagnose the plethora of diseases that were NOT actually COVID-19 such as pulmonary embolism, myocardial infarction, new onset atrial fibrillation with rapid ventricular response, community-acquired pneumonia, and sepsis among others.

Results

During the case series study period we completed over 2,200 tests with 24% being positive for SARS-CoV-2. Several nights in our clinic we were over 60% positive. Through our office testing we had 526 positive patients. We had an additional 620 positive patients from outside testing (a necessity due to the overwhelming amount of COVID-19 burden in our community). Those 620 positive patients were similarly triaged to mAb infusion, COVID at Home, video visit outpatient visits, or to inpatient care.

We enrolled 20 patients in our COVID at Home program while becoming the genesis for our local hospital's COVID home care program. Through the surge period the two programs saved over 120 beds in the hospital for inpatient care by utilizing the home approach (including oxygen), alleviating some of the burden on our overwrought local healthcare system. The home program through our office provided at home physician visits, oxygen therapy, lung ultrasound, dexamethasone, anticoagulants and close monitoring with adjunctive video visits. Patients chose this program for many reasons including the desire to stay home with their loved ones. We had no deaths in our program and no hospital admissions or readmissions. Our patients came to the program directly from our clinics, local emergency departments, or from inpatient hospital stays.

The monoclonal antibody infusion wing of our attack began in mid-December 2020 when mAb's became available. We sent 114 high risk patients for mAb infusion at our local hospital's infusion center. Of those patients only 2 required hospitalization during our study period. We had 39 patients who qualified but refused the mAb treatment. We also missed 97 qualified patients due to either late results from outside clinics/laboratories or a delay in our clinicians' learning curve in initiating this mode of treatment. Our only choice for mAb infusion initially was bamlanivimab. Eventually Regeneron became available as well as Eli Lilly's bamlanivimab and etesevimab product.[18,19] It should be noted that we first sensed the burden of COVID variants in our locale when bamlanivimab began to fail as a mAb infusion. The week after our study period ended, we noticed at least 3 hospitalizations after infusing bamlanivimab alone – a harbinger of things to come.[20,21]

As far as safety is concerned, we had zero staff to staff disease transmission, zero patient to staff transmission, and zero staff to patient transmission. This greatly enhanced staff confidence and trust in our methods which ultimately helped improve our patient outcomes. Also, it helped us achieve an over 90% staff vaccination rate by late winter.

Effect on Hospitalization and Mortality

As shown in Figures 3-5, the results of our approach were manifested in fewer hospitalizations, less mortality, and fewer hospital readmissions. This more aggressive approach to COVID care can be replicated in most outpatient office settings and in nursing homes. While safely honing the primary doctor's clinical experience with novel disease, this method allows other morbidity and mortality causing

continued on page 44

continued from page 43

Figure 2: The Difference between Triage to mAb Infusion Time for Symptomatic High-Risk Patients based on COVID –19 Testing/ Treatment Model

Timeline of Covid 19 Care for Symptomatic Patients			
Outpatient Testing at Other Facility Patient #1 56 yr. old male with cough and diarrhea. Started 2 days prior		Point of Care Testing at EFP Patient #2 44 yr. old male with cough and fever. Started 2 days prior	
Thursday Day 3	2:30PM Patient called for an appointment. Scheduled for a Video Visit In the Walkin	Thursday Day 3	1:15PM Patient contacted the office and left a message for the provider complaining of Covid like symptoms
	5:15PM Video Visit completed. Covid test ordered for outside lab.		1:34PM Message reviewed with provider and Covid test ordered.
	5:46PM Lab order created and faxed to the outpatient facility. Patient made aware that they will hear back from the facility with an appt.(appt not made on the phone)		1:50PM Drive Thru Testing Provider discussed history with the patient. Vitals and exam done as needed. Plan discussed and educated on treatment and recovery
Friday Day 4	9:10AM Call made to the facility to confirm appointment has been made		2:35PM Positive results called to the patient. Guidance given and questions answered by the assistant
	10:30AM Patient went to outside facility for testing only. **Exam not included		2:56PM PCP called the patient to scheduled a follow up Video Visit in 3 days with subsequent appts as needed
Saturday Day 5	11:09AM Call report to on call provider from facility with positive results		2:59PM Chart reviewed for COVID mlAb infusion qualification
	11:35AM Call made to the patient with the results. Plan discussed and educated on treatment and recovery		3:56PM Provider approved orders for infusion. Call made to patient to schedule infusion and appropriate orders sent to facility
Sunday Day 6	9:35AM On call provider called to check on patient		
Monday Day 7	8:51AM Call made to patient to schedule Video Visit Chart reviewed for eligibiity form	Friday Day 4	8:00AM Patient received COVID mlAb infusion
	9:43AM Video Visit completed with provider		
	10:30AM Orders fax to Infusion Center and appt confirmed		
	12:00PM Patient received COVID mlAb infusion		
Notes	patient was tested without exam -EFP was involved In patient's care through the weekend		Note that patient had exam while being tested

illnesses to be diagnosed in a timely fashion. This keeps hospitals functioning in a manner similar to pre-pandemic conditions. Also, our office which was established 43 years ago has never known more productive months than October 2020 and January 2021.

The Future

This model for COVID care forms a playbook for pandemic care in the future. Not only useful in a permanent community setting as our own, this is also a model that could be used to stop surges on a local level (Michigan 4/21) or even in different countries (India, Brazil 5/21). This science-based method is portable and could be used to tamp down COVID flares as needed, anywhere. For example, the recent Ebola outbreaks (2/21) were quelled in West and Central Africa by giving mAb's to patients with early symptoms and blanket vaccinations for affected communities. We can and should do the same given the high transmissibility of an airborne disease from pre-symptomatic patients such as in COVID-19.[22]

Thus, we find that COVID-19 is a primary care disease, as are all pandemics. By increasing our staff's involvement and ownership of this process, using pandemic history as a guide, and utilizing science-based medical treatments and prevention, we have seen a real time community benefit. The attitude that this is "everyone's pandemic" has settled into the very fiber of our practice, giving us a better vista for the remainder of this pandemic – and for novel infectious diseases that are certainly looming in our future.

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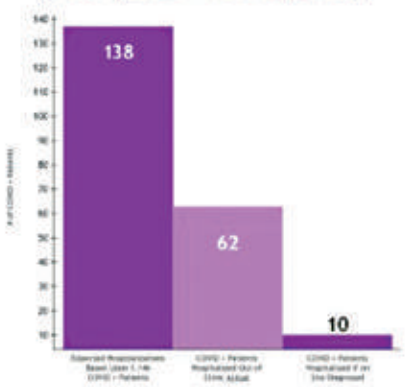

Figure 3: Our Model's Effect on Hospitalization Compared to Community Hospitalization Rate

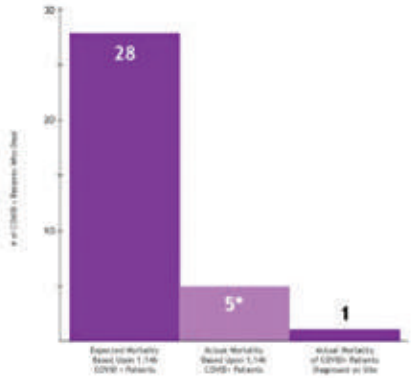

Figure 4: Mortality Difference Using Clinic Model
[*- Of the five patients who died during the study period, four were diagnosed outside of our clinic testing but were followed using our model's platform. Three of those four were not reported to us until well into the immunopathologic phase of the illness.)

Another Way of Comparing
(Oct 5, 2020 - Feb 28, 2021)

	Southern Tier	COVID Clinic Model	COVID Clinic
Case Fatality Rate	2.4%* (range)	0.44%	0.19%
Hospitalization Rate	12%* (range)	5.24%	1.9%
Hospitalization Death Rate	15.8%	14.3%*	0.19%
Readmission Rate	11%	6.7%*	0%

Figure 5: A Comparative View Based Upon Various Community Indices
[*- Case Fatality Ratio and Hospitalization Rate were calculated using data from local health department, UHS Hospital's Statistical Team, Johns Hopkins Coronavirus Tracker and the New Times Coronavirus Online Tracker. The reason we used the word "range" is because these percentages change daily. We were also looking at data based upon symptomatic cases while disqualifying the nursing home cadre of patients. We see nursing home patients in the hospital but during the study period they were not usually seen in our office. Also, our hospital death rate was increased by nursing home patients who we cared for while hospitalized. We actually had no readmissions as the 6.7% noted above reflects two patients who were initially admitted to the hospital before our study period.]

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For additional endnotes and resources, see page 52.

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Pandemic Teaching:
What We Have Gained and Lost

By Kelly Kirkpatrick, DO; Azmina Bhayani, MD, MPH and Gabrielle Surick, MD

In March 2020, during the throes of the SARS-CoV-2 pandemic, similar to many aspects of life, in-person residency didactics and precepting came to a screeching halt. As faculty of a family medicine residency program, we quickly had to pivot our weekly in-person didactic sessions and much of our precepting of residents and medical students to remote learning. Like many programs across the country, we had to significantly change the way we taught so that our learners could remain engaged and connected, all during a time of increased burden on both residents and faculty. Throughout this process, we have gleaned lessons about what we have gained, as well as lost through remote teaching. Now, more than a year into overhauling our teaching curriculum and trying to re-format it with purpose, we have landed on a hybrid model of in-person and remote learning, as we attempt to maximize the best of both worlds.

Last year, as residency programs scrambled to provide remote learning for residents and students, we moved all didactics to Zoom. This allowed residents and students to continue to attend didactics regularly, despite restrictions on meeting in person. For learners, the flexibility of being able to attend didactics from wherever they were (including from their couch at home) opened up learning opportunities. Learners on inpatient medicine who ordinarily would not have been able to attend in-person didactics were able to easily tune in to weekly learning. For residents and students who preferred independent learning or those who were unable to attend in real time (i.e. those on overnight or away rotations, or on vacation), having the ability to record didactic sessions allowed them to have a repository of rich learning resources that they could access at their fingertips and at their convenience. Our program built on this concept and created a Google Drive database with learning materials by subject and rotation with additional links to important resources (AAFP articles, exam prep sites, etc.), so learners could work through curricular resources at their own pace and target specific content areas.

Remote learning also had benefits for faculty and our residency program at large. As presenters, it taught us how to engage learners in new ways, including using interactive polling methods (e.g., Kahoot, Poll Everywhere), flipped classroom approaches, and utilizing breakout rooms for small groups. For the residency program, remote didactics allowed for the ability to have speakers from outside our institution or local geographic area, including those with limited time who may have otherwise declined an invitation to speak had it involved traveling to our site. It also allowed us to combine some didactics with our sister residency program in upstate New York, which has let us share clinical and organizational perspectives, as well as expand the pool of speakers and share the responsibility for teaching among more faculty.

Similarly, tele-precepting created opportunities for learners and faculty. For residents and medical students, precepting remotely taught them how to appropriately present in front of patients and

look things up quickly in real time, as well as document more efficiently. Medical students learned how to instruct patients to take vital signs and strengthened their basic physical exam skills by coaching patients on how to palpate their abdomen, for instance. It allowed learners to better meet patients' needs, such as being able to talk during a patient's lunch break or write medical necessity letters for them and send them electronically. Remote visits allowed all learners time to delve into more social (e.g., mental health, social determinants of health) and administrative (e.g., medication reconciliation, referrals, specialist consult notes) issues during patient visits.

Unfortunately, remote learning quickly revealed its flaws as well. For learners, the lack of in-person didactics represented lost opportunities to interact in person with their colleagues and faculty and was perceived as loss of community. Gone were personal conversations and organic learning opportunities or research or QI projects that ordinarily would have stemmed from small talk. Residents also expressed frustration that between remote didactics and limited rotations, their hands-on learning experiences had diminished drastically. Psychosocial interactions, including Balint group, behavioral skills workshops, and resident support group, also felt much less personal, and difficult conversations became even more difficult to have over Zoom. For presenters, including faculty, the Zoom "doom" quickly emerged when a speaker was met with a large grid of 'video off' black screens and decreased engagement. For the program as a whole, remote didactics meant for a less tight-knit residency community.

Remote precepting also had disadvantages. The most obvious flaw was lack of in-person learning for hands-on skills, including physical exam skills and procedures. For medical students whose rotations had been converted into telehealth, often with only one preceptor, their exposure to different patient care styles and clinic flow was limited. Remote preceptors sometimes felt disengaged and frustrated at their ability to help residents with patient diagnosis, exam skills, and schedule management.

Given the benefits and disadvantages of remote learning, our residency program is deciding where to take our curriculum next and will be adopting a hybrid model. As the number of CoV-2 cases drop and vaccination rates rise, we have been able to resume in-person didactics with fully vaccinated individuals. As we plan for the next academic year, our program has chosen a mixed remote and in-person model of learning. For our in-person sessions we hope to maximize procedural workshops, case-based small group discussions, support groups, psychosocial didactics, and program meetings, while during our remote learning weeks, we will try to maximize interactive lectures from engaging speakers across the country. We also plan to continue to collaborate with our sister residency program, as well as foster partnerships across residency programs and disciplines.

Most patient care sessions are now in person, but we would like to continue to have residents and students participate in telehealth in some capacity, as we feel this is a valuable skill. For students, it allows for them to have "continuity of care sessions" to follow up and discuss lab results, help with prior authorizations, and increase their sense of satisfaction of taking ownership of their patients' needs. For both medical students and residents, we believe telehealth will be a part of their future patient care and is a skill they need to acquire during their medical education.

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Lessons Learned in Offering Wellness Groups for Primary Care Providers During Pandemic Times: A Call to Action

By Nayla M. Khoury, MD, MPH and Maureen Ryan, PsyD

Introduction

The plethora of demands primary care routinely encounters, such as limited time, high patient volume and needs, structural barriers interfacing patient healthcare, and the risk for professional burnout, are well documented.[1,2] The current global pandemic has presented anything but routine challenges for primary care to navigate. While these times are unprecedented, a literature review of previous pandemics suggests that 10% of healthcare providers may develop PTSD and many more may be impacted by symptoms of burn-out.[3] National data collected over the past year suggest that the mental health toll of the current pandemic is greater than anticipated, with one quarter of essential workers having been diagnosed with a new mental health disorder since the start of the COVID-19 pandemic.[4]

New York State, as the early center of the COVID-19 pandemic in the United States, required primary care to mobilize rapidly in response to a catastrophic event with limited guidance or precedent for how best to support families in crisis. Family physicians, given their unique role within primary care, were tasked with managing patient care and supporting family resiliency in the context of rapidly changing medical protocols, fundamental shifts in the structure of service delivery, reduced resources, and increasing behavioral health needs. More than ever, family physicians functioned as pivotal anchors for their communities in the midst of profound uncertainty. The nature of the pandemic placed family physicians in the dual roles of having to help families on many levels while simultaneously navigating the catastrophic stressors themselves.

Project TEACH offers support to New York State PCPs through behavioral health phone consultations, in-person psychiatric consultations, trainings on a variety of media platforms, and linkages and referrals to community resources. In recognition of the ever-growing challenges that PCPs faced, and continue to face as a result of the pandemic, Project TEACH developed and piloted wellness groups designed to support self-care, provide clinical advice, and partner with providers to help strengthen health systems. In July and October 2020, PCP wellness groups were piloted to assess feasibility and interest for a drop-in group designed to introduce key concepts of resiliency, promote resilience among providers, and identify methods for enhancing family resilience among patients. The process of offering this group to PCPs, first in the greater Syracuse area and then to the entire state of NY, illuminated tensions that arise when developing groups to support overworked and busy physicians, particularly for family physicians.

Group Structure

The wellness initiative emerged from informal observations that PCPs were increasingly using phone case consultations with Project TEACH psychiatrists to voice their own uncertainty, sense of loss, and emotional response to the pandemic. The conversations occurring within the context of patient-based phone consultations were felt to be emblematic of the unique dialectic PCPs, and particularly family physicians, experience secondary to the pandemic. Family physicians are pivotal sources of community strength, yet personally and professionally may feel vulnerable to systemic stress. They help hold patients' heightened anxiety, while simultaneously navigating the uncertainty of living through the same catastrophic event themselves. In recognition of the need for more formal opportunities to support wellness and resilience, a group model was developed to help mirror the dual task that PCPs have been charged with during the pandemic – caring for their patients while caring for themselves.

The first 4-session group held in July, 2020 (Series 1) was structured around providing short mindfulness and compassion-based practices with debriefing at the start and end of the group to help bolster wellbeing. Participants were empowered in each session to self-identify what they would experience as most beneficial to discuss, whether it was a challenging behavioral health case, extended mindfulness exercises, or other special topics. Based on feedback from participants, the group's focus was altered in framing and structure for the second 4-session group held in October, 2020 (Series 2) to include a more structured resiliency-based framework for PCPs in their work with patients and families. Short mindfulness and compassion-based practices to support provider resilience continued to be offered in Series 2. Each of the two series of group sessions utilized a drop-in open enrollment model. Approximately 10-15 PCP's registered for each session in Series 1, which was limited to Central New York in piloting the program. During Series 2, registration increased to 12-20 for each session and was expanded to PCPs throughout New York State. Online satisfaction surveys were provided to participants following each series for feedback regarding structure, educational value, and suggested topics of discussion for future sessions.

In selecting self-care practices, efforts were made to identify brief exercises that could be easily integrated into the rapid pace of primary care, such as grounding practices like "5-4-3-2-1" or the compassion practice "breathing in for oneself and out for the patient."[5] The materials from these drop-in groups and information on potential future groups can be found on the Project TEACH website: https://projectteachny.org/resources/. Given the demand for these wellness

groups and positive feedback from participants in both sessions, a third round of PCP wellness groups of four sessions was provided statewide in February through March, 2021.

Group Process and Emerging Themes

Themes that emerged during the process of these wellness groups included: 1) Challenges associated with creating space for self-care within busy workplace settings; 2) The importance of finding ways to increase community and reduce a sense of isolation; and 3) The unique role that PCPs, particularly family physicians, play in identifying structural sources of distress and advocating for solutions.

In Series 1 there was a strong tension between PCPs wanting a space to discuss their own wellness and mental health needs and the pull to discuss difficult behavioral health cases they felt alone in managing. They readily identified their own high levels of stress and anxiety, yet the discussion frequently defaulted to finding concrete solutions for their patients. One PCP in the cohort insightfully observed, "I know I need this [mindfulness exercises offered during group] but I can't switch out of this headspace [of work]." The absence of readily available school supports and other mental health resources for children and families during pandemic times in this largely rural cohort of PCPs genuinely resulted in a feeling of being "left holding it all." Self-care, in this case and for many, was primarily about surviving the workday and prioritizing patient needs. This stark reality of primary care in under-resourced communities, and the level of personal sacrifice asked of family physicians during the pandemic was striking. Being mindful of this reality, Series 1 balanced providing collective resources to address specific case-based questions and holding space for providers to also share together and support one another in practicing during pandemic times.

Series 2 utilized a more structured and educational model for promoting discussion. The focus shifted more directly to resilience as the theme and pulled for ways providers and patients alike were thriving, in spite of numerous systemic stressors. Resilience concepts were explored in each group, such as family resilience, with a focus on "the potential for transformation and positive growth."[6] Ensuing discussions identified how patients and providers alike were holding the emotional demands of virtual schooling, shifting schedules at school and at home, and the need for new rituals.[7] The group explored the role of PCPs in supporting children's and families' sense of active agency and meaning making in the face of daily challenges.

In Series 2, the group composition was more diverse geographically, and demonstrated a strong desire for focus on personal wellness. The strength-based and meaning-ascribing functions offered by a resilience framework appeared to enhance the second cohorts' increased comfort with sharing personal experiences, including the fear and intense tragedy of losing a patient to suicide.

The desire for peer connections was apparent in both Series 1 and 2. One provider new to a small rural community made a connection in the group and planned to connect over an upcoming holiday. Isolation was named as a primary challenge for all during this time, and meeting virtually in this way was one way to find connection and camaraderie.

continued on page 50

continued from page 49

Lastly, structural issues faced by patients and providers were discussed frequently. The global stressors of COVID-19 and racism were brought into the forefront. PCP participants in both Series 1 and 2 noted challenges of helping teenagers navigate watching potentially traumatizing social media, such as the killings of people of color at the hands of police. One PCP of color discussed his experience as a provider navigating predominately white communities and the discussions he has preparing Black and Latino teenagers for addressing this themselves. Another discussed challenges in her community regarding rising unemployment. As pillars of their communities, PCPs have an important role in understanding structural/systemic issues affecting their communities and impacting the health of children and families. These issues were magnified during the pandemic, and tasked PCPs with finding ways to hold hope for themselves and their patients.

Future Lessons: A Call for Change

The Project TEACH wellness groups highlighted the critical challenges many PCPs face in attending to personal wellness within the context of overburdened healthcare systems. Emergent themes highlight the critical need for structural changes to better support the resilience during the pandemic and beyond. The process of piloting and revising a support group to meet the needs of colleagues during pandemic times illuminated important experiences of PCPs across New York State, including the frequently competing needs for self-care and the logistics and weight of caring for patients with increasing behavioral health needs.

The challenge of creating time for self-care as a healthcare provider mirrors the conflict between values that have been described as integral to the culture of medicine and those that support a culture of wellness. The culture of medicine values a focus on putting patient needs first and devalues asking for help or showing vulnerabilities.[8] It also speaks to larger systemic forces within many busy practices that don't allow space or time to switch into a more reflective mode or take time for one's own wellbeing. In such environments, an hour of personal wellness may in fact be counterproductive when the focus is on efficiency. The themes of time challenges, and fostering health systems and environments that allow space for reflection and self-care, are not new for primary care physicians-- these issues have become exacerbated in the context of added pandemic stress.

A resilience framework may offer PCPs one way to reconcile the seemingly dichotomous experiences of strength and vulnerability or caring for self and other. A focus of holding onto compassion and hope in the midst of crisis can help reframe challenging patient experiences for both patient and healthcare providers. Compassion practice can be sustainable in that it involves connecting with patient suffering while also cultivating hope; such focus on patient and family strengths and agency even in the midst of crisis can help reframe the patient and healthcare provider experience, set more realistic expectations, and improve long-term wellbeing. Simultaneously, themes from the groups highlight a critical dearth of patient resources, which was only exacerbated during pandemic times.

The process of adapting the Project TEACH wellness groups also highlighted structural adaptations needed in healthcare systems. Previous studies echo this need, with one recent study finding that the increasing expectations from patients and other healthcare specialties, compounded by limited resources and/or the ability of PCPs to independently place limits on such demands, is a huge driver of burn-out.[3] Of course, finding solutions to these systemic problems is not simple. Whether it is shifting towards a multidisciplinary collaborative care model, or improving agency around time management with complex patients, solutions must focus on providing not just space to support individual wellness but collective avenues to support systemic change. The pandemic may be ending sometime in the future, but the challenges faced by PCPs, particularly family physicians, will surely remain without systemic structural change.

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continued from page 28
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continued from page 37
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continued from page 45
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