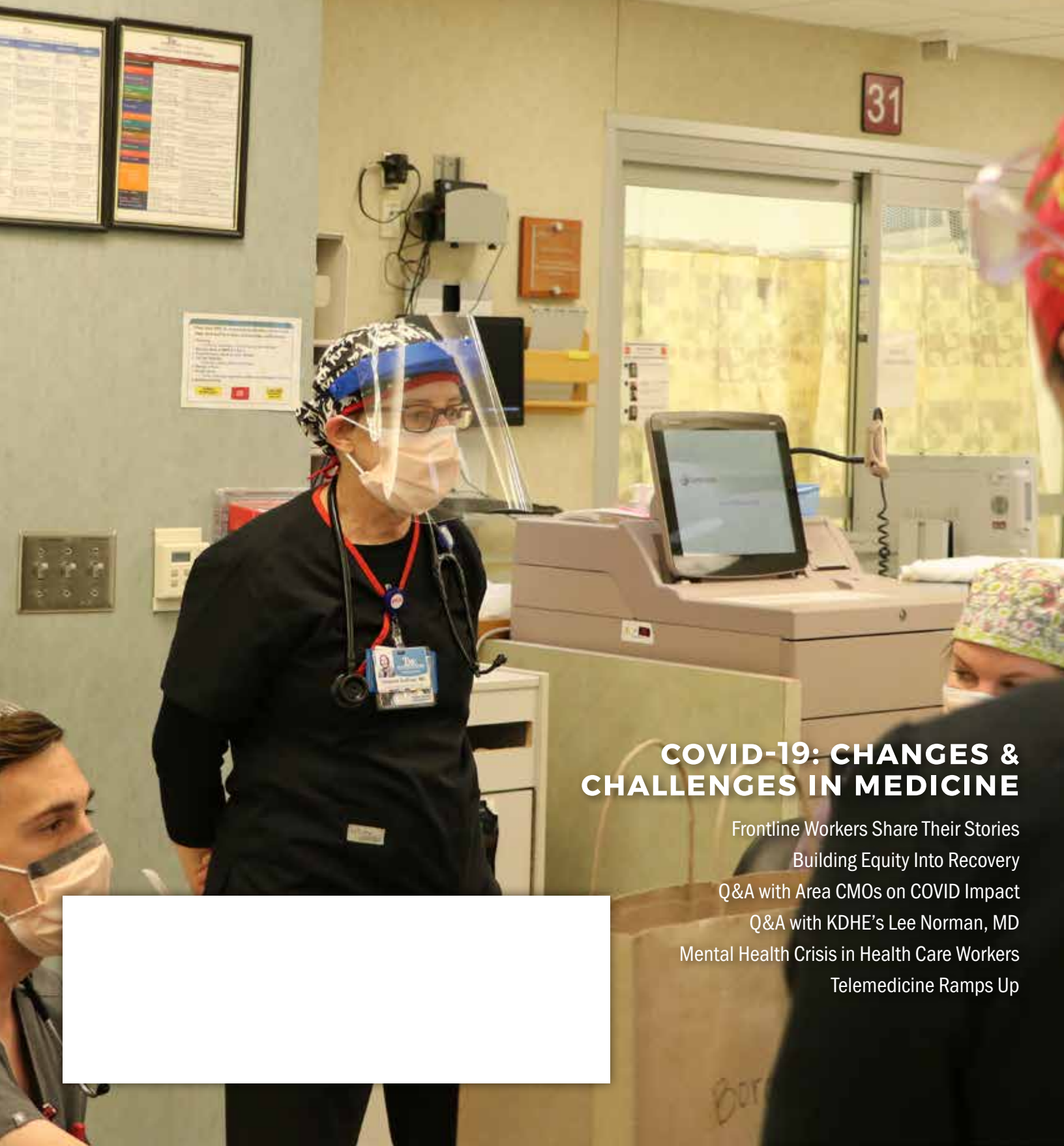


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COVID-19: CHANGES & CHALLENGES IN MEDICINE

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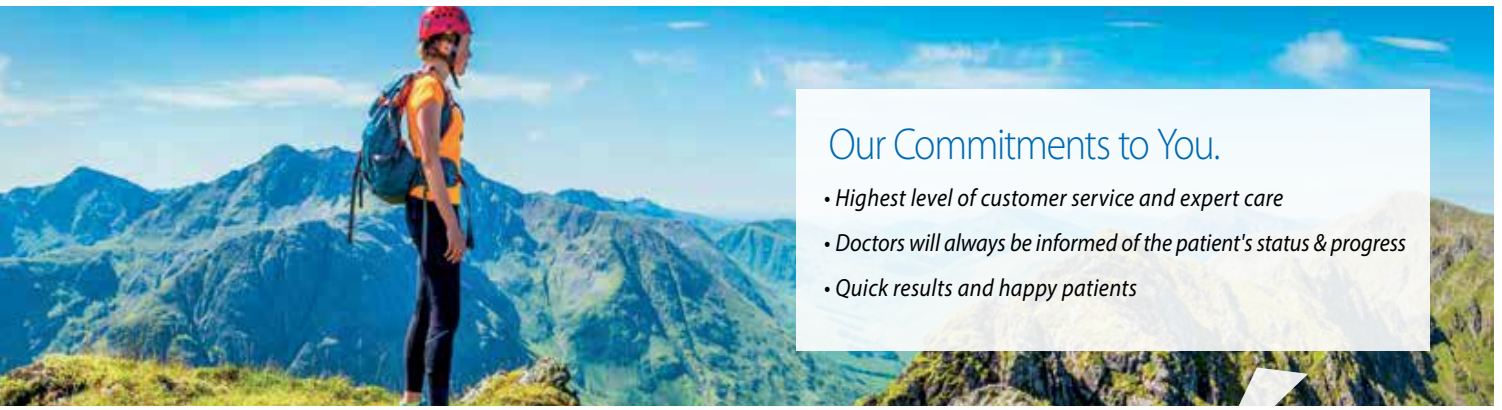
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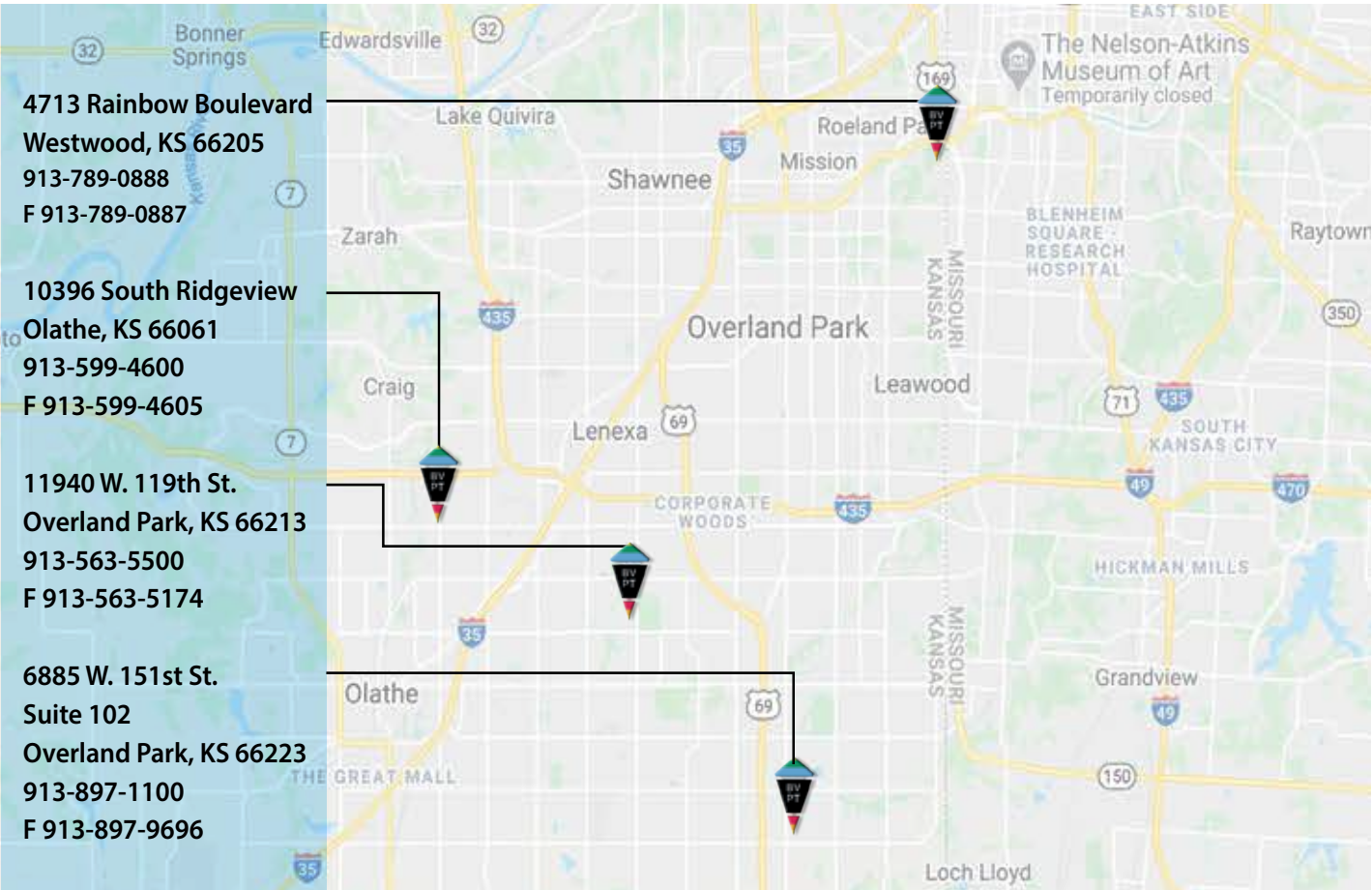
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Kansas City MEDICINE

— SECOND QUARTER 2020 —



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On the Cover: Christine Sullivan, MD, meets with residents during a shift change in the emergency department at Truman Medical Center. Dr. Sullivan is associate dean for professional development at the University of Missouri-Kansas City School of Medicine. (photo by Keith King, courtesy of Truman Medical Center)

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Medicaid Expansion to Appear on August 4 Missouri Ballot

Missouri voters on August 4 will vote on a constitutional amendment to expand Medicaid according to the provisions of the Affordable Care Act. The ballot proposition is the result of 350,000 petition signatures gathered by Healthcare for Missouri, the group championing the initiative. KCMS and the KCMS Foundation support the proposal, which will be on the ballot as Constitutional Amendment 2.

COVID-19 heightens the need for Medicaid expansion. Between March 21 and May 7, nearly 500,000 Missourians filed for unemployment. Besides losing employment, these workers often have lost insurance.

In a May 20 commentary in the *Kansas City Star*, Qiana Thomason, president and CEO of the Health Forward Foundation, emphasized that COVID-19 has laid bare existing inequities. “Too many have lost jobs and health insurance as businesses closed. Too many of those who kept jobs lack paid sick leave. ... These and other inequities make too many of our fellow Missourians more susceptible to the negative health and economic consequences of the pandemic.”

She continued, “Medicaid expansion would make our families healthier, our communities safer and our economies stronger.”

KCMS and the KCMS Foundation are compiling a list of member physicians supporting Medicaid expansion for use in media advertising. To add your name to our supporter list, visit kcmedicine.org/expand-now. For more information on Amendment 2, visit YesOn2.org.

...

In Kansas, advocates are expected to renew their push for Medicaid expansion in 2021 after a bipartisan compromise bill stalled in this year’s Kansas Legislature.

#GetCareKC Campaign Addresses Patient COVID-19 Fears



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YOUR HEALTH
CARE**
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Amidst ongoing concerns about patients delaying health care out of fears of contracting COVID-19 at a physician office or hospital, the Medical Society has rolled out a set of materials encouraging people to not hesitate seeking medical care—both urgent and non-urgent.

#GetCareKC provides a set of social media graphics around the message, “Don’t delay your health care ... Your KC physician is ready to help.” The campaign also includes

graphics reminding parents about the importance of keeping immunizations current. Supporting the graphics is a section of the KCMS website with information about safety precautions implemented at clinics and hospitals, along with further details on the value of early intervention and preventive care.

The #GetCareKC graphics and campaign information are available at kcmedicine.org/getcare-physicians.

KCMS Annual Meeting Set for October 21 at Arrowhead

Physicians and partners will bask in the glow of the Chiefs’ historic Super Bowl victory at the Wednesday, October 21, 2020, Annual Meeting, which will be held at Arrowhead Stadium. On the program will be a panel of mayors from across the region discussing health care in Kansas City:

- Quinton Lucas, Kansas City, Mo.
- Peggy Dunn, Leawood
- Eileen Weir, Independence
- David Alvey, Unified Government of Wyandotte County and Kansas City, Kan.

Moderator will be Bridget McCandless, MD, MBA, KCMS past president and former CEO of the Health Forward Foundation. Also at the meeting, KCMS awards will be presented. The meeting will held via Zoom if COVID-19 conditions warrant. Watch for further announcements.



Heroes and Zealots

By Michael O'Dell, MD, MSHA, FAAFP

Heroes and Zealots. Protectors and Jailors. Voices of reason and absurdists. Oh my, what we physicians have heard applied to our profession over the past many months.

We scour our experiences for some similar past pandemic experience. An experience that teaches us. A way to avoid prior mistakes.

The writings about the so-called Spanish Flu pandemic in 1918 do little to inform us. As an H1N1 Influenza virus, the 1918 flu is unlike coronavirus in its infectivity and spread. It has been difficult to state where the 1918 pandemic originated, although most experts now point to China.¹ The subsequent introduction of rapid mass travel, changing population density in cities, let alone advances in virology since that time, also alter our ability to apply lessons from the 1918 pandemic. And there is a puzzling lack of scientific or even lay literature about what began in 1918.

The 2003 SARS outbreak was due to a coronavirus. But the 2003 SARS epidemic was not as widespread and infected roughly 9,000 persons, not the millions seen in today's pandemic. But it was instructive as a preparatory event. The director general of the World Health Organization at the time, Dr. Gro Harlem Brundtland, stated:

"SARS pushed even the most advanced public health systems to the breaking point. Those protections held, but just barely. Next time, we may not be so lucky. We have an opportunity now, and we see the need clearly, to rebuild our public health protections. They will be needed for the next global outbreak if it is SARS or

Medicine remains naïve in its ability to balance its response to infectious illness and response to health damage from social conditions.

another new infection."²

Literature offers a more colorful view of our everyday experience now. Two writers come to mind: Albert Camus and Henrik Ibsen. These two classics mirror the responses of our patients and community during this pandemic.

The first, Camus, has been recalled widely during this pandemic for his book, *The Plague*. Despite Camus' existentialist and absurdist philosophy, deep admiration emerges as central character Dr. Bernard Rieux goes about caring for the afflicted.³

Lesser known, but equally instructive, is Henrik Ibsen's play, *An Enemy of the People*.⁴ In this play, the central character, Dr. Thomas Stockmann, aggressively acts on a contaminated water report that threatens his town's economic lifeline, a large bathing complex. As the city dwindles with this financial loss, anger turns towards Dr. Stockmann. Intimidated and disrespected, Dr. Stockmann and his family are left isolated.

There have been many calls to use sci-

ence in decision-making in our response to COVID-19. These calls are reassuring, but we must be mindful of the limitations of what we know and can apply. While medicine has much to offer in disease prevention and treatment, we have had little to offer in broader areas of health. As the World Health Organization states, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."⁵ Our lack of ability to meaningfully address social issues, in particular, limits the ability of physicians to return our community to health.

Medicine remains naïve in its ability to balance its response to infectious illness and response to health damage from social conditions. In this pandemic, job loss and social isolation have been lead actors in health damage. How will our actions as physicians be judged? Most physicians enjoy admiration, as is found in Camus' portrayal of Dr. Rieux. But we are alarmed by *An Enemy of the People* with its outcome of Dr. Stockmann's fall from grace and his isolation from the community.

We would do well to follow Dr. Brundtland's 2003 warning with more effective action. Physicians should advocate with the lay community to make the necessary investments to strengthen our public health structure, so we can be better equipped to respond to COVID-19 as well as subsequent pandemics. We can also advocate for building a fairer economy. One in which illness is not a path to poverty. An economy in which poverty is not associated with illness and premature death. ☺

(continued on pg. 9)



thank you

To all the **doctors**
nurses ICU staffers
practice managers first responders
infectious disease specialists
intensivists *medical examiners*
geriatricians **nurse practitioners**
respiratory technicians
ambulance drivers *pulmonologists*
epidemiologists *social workers*
life sciences engineers **microbiologists**
vaccine research lab technicians
pharmacists *hospital administrators*
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pathologists *hospital housekeepers*
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Our Responsibility to the Community

By Betty M. Drees, MD, FACP, FACE, KCMS President 2020

Physicians in the United States have a long history of holding themselves to the highest of standards of ethical conduct. These standards are upheld through a combination of organized medicine, individual state statutes and boards of healing arts. At the first meeting of the American Medical Association in 1847, a Code of Ethics was adopted, and although it has gone through a number of revisions, it is still in effect today (<https://www.ama-assn.org/topics/ama-code-medical-ethics>).

Reflecting on the challenges of the coronavirus pandemic of the past four months, I am proud of how committed the physicians in our community are to the principles of the Code of Ethics in response to this crisis. This indicates that these ethical principles are ingrained in the professional identity of our colleagues and guide their actions on a daily basis.

Our colleagues are leaders in changing practice models to accommodate care of patients: they care for the sickest of patients even at the risk of becoming infected themselves; they cooperate across health systems to provide access to care; they advocate for their patients and health care teams; and they provide expertise to the public about the science of the coronavirus. The response of the health care workforce, public health departments and health care systems is heroic in their efforts to care for those who are ill and prevent avoidable transmission. Articles in this issue of *Kansas City Medicine* cover many aspects of that response.

As we enter the next phase of the battle against COVID-19 with expanded virus

testing and the resumption of routine clinical care, it is relevant to revisit the responsibilities of physicians to the community in Chapter 8 of the Code of Ethics. This includes the responsibility collectively “work with others to develop public health policies that: 1) are designed to improve the effectiveness and availability of medical services during a disaster; 2) are based on sound science; and 3) are based on respect for patients.”

The knowledge about the novel coronavirus is changing rapidly ... our ethical responsibility to participate in education of the public is especially critical now.

Furthermore, as individual physicians, we should participate in quarantine and isolation procedures to protect the public and ourselves. This includes helping to educate patients and the public about the “public health threat, potential harm to others, and benefits of quarantine and isolation.”

The knowledge about the novel coronavirus is changing rapidly and is a tribute to global scientific research efforts. However, it creates a challenge to implement new knowledge and keep the health care community and the public informed.

This means that our ethical responsibility to participate in education of the public is especially critical now. As many of our members have reported, our patients may be afraid to seek either care for acute emergencies (e.g., strokes, appendicitis, heart attacks) or for chronic diseases (e.g., diabetes, heart failure, vaccinations) due to concern about risk of catching the coronavirus at the hospital or clinic. These fears may result in harm, even to the point of avoidable deaths.

Thank you to our members and colleagues who have reached out to help dispel these fears and improve timely and safe access to health care for the public. To support this effort, our Medical Society has rolled out a #GetCareKC campaign with educational materials including social media graphics and information on our website. See additional information in this issue of *Kansas City Medicine* about these materials. I encourage you to take advantage of them.

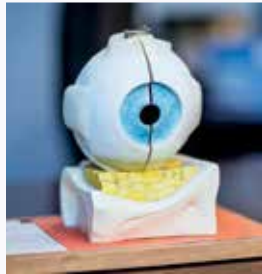
And thank you to the authors and editorial staff who contributed to this issue of *Kansas City Medicine* about COVID-19.



Betty M. Drees, MD, FACP, FACE, is dean emerita of the School of Medicine at the University of Missouri-Kansas City and president of the Graduate School of the Stowers Institute for Medical Research. She can be reached at bdrees@kcmedicine.org.

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After the Pandemic

By Charles W. Van Way, III, MD, Editor Emeritus, *Kansas City Medicine*

"Maybe all one can do is hope to end up with the right regrets."

~ Arthur Miller, *The Ride Down Mount Morgan*, 1991

We have endured a difficult time. And much as we may wish it, we're not through yet. COVID-19 will be with us into 2021 and quite likely into 2022. It is certain that this will pass, eventually. But what will we be left with? How will things be changed?

Arthur Miller was one of the great dramatic playwrights of the 20th century. He wrote often of catastrophic personal events. To be sure, that's what dramatic playwrights do. But he also wrote of recovery, of getting past the terrible event, of what comes next. The above quote seems to be appropriate for our time.

The closest historical comparison in modern times was the great flu epidemic of 1918-1919. Coming at the end of World War I, it spread around the globe, infecting perhaps one-third of the world population of about 2 billion. With a mortality of 2-10%, depending on location, it killed a lot of people. In the 1920s, the death toll was thought to be around 20-23 million. Subsequent estimates have varied wildly, from a recent figure of 15 to 25 million deaths¹ to a widely-cited estimate of 50-100 million.² Most likely, it killed 20-25 million people, considerably more than the war itself.

How long did it last? It was a very bad year. The Spanish Flu, as it was called, came in three waves: June-July 1918, September-November 1918 and February-March 1919. The second peak was the

Reopening the economy will be harder and slower than we would like. It's not simply a matter of having a news conference, telling restaurants to open and planning for a great football season.

worst. Some of the current concern about a "second wave" this fall comes from that collective and institutional memory. It's true that the 1918 pandemic was caused by the H1N1 influenza virus, while the present pandemic is caused by a very different coronavirus. But the fear of a second wave is legitimate and real. This fear should keep us worried and cautious, at least for the rest of this year and probably for a year or more.

What happened afterwards? The 1918 pandemic came at the end of a long and brutal war. The energies released after the war went on to produce the Roaring Twenties, a time of huge optimism, high spirits and great prosperity. But first, there was a depression in 1920-21, generally blamed on the shift from war production to peace. Was it partly due to suppression of the economy during the pandemic? Economists are still arguing about its cause.

Things are very different today. The U.S. and the world are at the end of a 10-year expansion. We will likely see a recession, if only from the enforced inactivity. How long will it last? That depends a great deal on how governments respond, not only here but around the world. Given that most governments are making it up as they go along, I'm only cautiously optimistic. Some days I'm seriously pessimistic. I mean, our next president, whomever he is, will be nearly as old as I am. If that doesn't make you nervous, you have nerves of steel.

REOPENING THE ECONOMY

But the most important factor is how individuals will respond. Small businesses, from restaurants to physician practices, were mostly closed. Will they reopen? If you're a 62-year-old internist and you now have to reopen and rebuild, will it be worth it? What if you're already struggling to run a restaurant? A plumbing business? A Fortune 500 company? Each one of those closed businesses will need to open their doors. It will come down to a lot of individual decisions by people who can choose whether or not to reopen. Many may not. Reopening the economy will be harder and slower than we would like. It's not simply a matter of having a news conference, telling restaurants to open and planning for a great football season.

A lot of people are going to be very cautious about risking themselves in crowds, for a long time to come. Events are cancelling through the end of the year. The travel industry is in for a long slog

to get back to where it was. Cruise ships? Airplane travel? Conventions in Las Vegas? They'll probably all come back, but it won't be soon. People feel they've been badly burned. The public memory is famously short, but it's not THAT short. Sure, we'll eventually have a vaccine. Maybe even an antiviral treatment. But when? Maybe by next year, maybe in several years. Before then, we're all going to live with a lot more uncertainty than we would like.

Working from home is going to be more feasible. The trend was headed in that direction before the pandemic. It will accelerate. A great many jobs, not just software development, can be done without an office. But a great many more cannot. In the health care business, we can't work from home. Telemedicine has only a limited place. We remain dependent on direct interaction with our patients. And if you hadn't noticed, a lot of hospitals are losing a great deal of money. It's going to be a lean few years, even after we reopen the hospitals to "elective" health care.

What about sports? Well Do YOU want to shut yourself into the Chiefs' stadium with 76,000 yelling, spitting and often drunk fanatics? Sorry, "fans?" Yeah. Me, neither. Bear in mind that 26 stadiums around the country are even bigger than Arrowhead. We're already talking about

playing Major League Baseball without spectators. The Tokyo Olympics have been moved to 2021. We might have basketball this winter, but I wouldn't count on it. And college sports? Colleges and universities will probably open for the fall term. Maintaining their sports programs will be a primary objective. But what will they risk? If one big football game can trigger an epidemic and close down your school, will you risk it?

DIFFICULT CHOICES

We have made and are making a lot of difficult choices. We make them one by one, as individuals. We make them collectively, as companies, institutions, communities and governments. Not all of them will be correct. We're not all going to go the same way and that's good. Having a lot of different decisions being made will allow us to learn from other people's decisions, both good and bad. We will need to be honest and tolerant about how we look at things. The states which open up early will be criticized, but those state governments are just as concerned about their people as other states. We should respect that. More, we should learn from the results of their choices. We are all in this together. Learning from the results will help the rest of us. Making difficult choices

into partisan political issues will hurt us.

Unexpectedly, we now have an opportunity to make progress on some of our toughest racial problems. There has been a lot of public support shown in the last weeks for substantial reform. Race-based inequities have plagued our country for centuries. There is a clear need for improvement, and not just in our police departments. Will we make wise choices, or will we simply posture and point fingers?

We hope that when we get to the other side of this, be it a few months or a few years from now, that our choices will look to have been decent and well thought out. And we hope our mistakes, individually and collectively, will cost as little as possible. As Arthur Miller put it, we hope that we will have "the right regrets." ☺

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City. He can be reached at cvanway@kc.rr.com.

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FROM THE EDITOR

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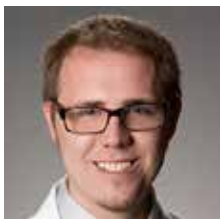
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View from the Front Lines of COVID-19

PATIENTS FACE FEAR, ISOLATION; HEALTH CARE TEAM COLLABORATES TO OVERCOME A NEW AND POWERFUL DISEASE

Two members of the KCMS Board of Directors have been among the many Kansas City-area physicians working on the front lines at local hospitals to treat COVID-19 patients.

Brian Mieczkowski, DO
Pulmonologist
Research Medical Center



My experience on the front line at a regional, quaternary hospital has been a combination of intensity and organized chaos, but at times, beauty. In Kansas City, we were fortunate to be able to observe experiences from other areas of the country prior to having to be on the front lines ourselves with the COVID-19 pandemic. It felt similar to being in line for a roller coaster. We could see the crisis and know at least part of its course. We could talk to others that have been on the ride before, then update plans and better prepare. And then, wait for our turn to experience this pandemic firsthand.

Given my increased level of exposure to this virus as a pulmonologist, my family made preparations at home once our practice had its first patient with COVID-19. My wife and four kids set up what we refer to my “isolation habitat” in the walk-out basement of our home to keep them safe, and potentially limit the spread of COVID-19. They cleared the space—leaving a bed, work station and a few objects that were too heavy to move. They hung plastic sheeting across the doorways to seal

I was anxious while putting on my PPE—double-checking edges and seals. I felt the anxiety as the roller coaster was climbing the hill for its first drop. I was now on the ride and I embraced it.

these off. They set up a kitchenette with a microwave and a small pantry for me. This is where I predominantly have lived during COVID-19.

As a pulmonologist, I have cared for patients with a wide range of conditions. On my first day on the COVID-19 front line, I was working at a regional hospital. We were caring for a patient with known COVID-19 positive pneumonia. We reviewed PPE protocols over and over before walking into the patient’s room. Despite this, I was anxious while putting on my PPE—double-checking edges and seals. I felt the anxiety as the roller coaster was climbing the hill for its first drop. I was now on the ride and I embraced it.

As I opened the door and entered the patient’s room, I was surprised at what I found. There was no monster. No scary drop or turn. There was a sweet elderly lady sitting up in bed greeting me with a smile and asked how I was doing before I could even introduce myself. She came to us already having been on a many-week journey with COVID-19 and ultimately needed to transfer to Research Medical Center, our “downtown hospital” as she called it. I saw her several times along her journey. Her condition waxed and waned, but she always greeted me with a smile

when she could muster the energy. She became the face of this crisis for me. Not a monster, but a compassionate patient that contracted an illness by happenstance and needed a team bring her through it.

Never in my career have I seen the kind of collaboration and coordination of care than I have during this pandemic. Sorting through new information was a job in and of itself—what we knew Monday would often change by Tuesday. Health care systems within Kansas City came together in an impressive way.

Despite a sense of intensity, there was also a sense of balance. At a physician practice level, we reassigned previously established roles in order to level out the burden and fatigue. Our outpatient physicians would review scientific articles and clinical protocols while in clinic to help our inpatient physicians swim through the ocean of information. We leaned on each other for support and ideas. Primary medicine and specialists held team meetings in our dictation rooms to coordinate care and collaborate on treatment regimes. Inquiry and communication superseded ego or logo. This is what medicine should be.

I was one of the physicians assigned to the specialized COVID-19 inpatient unit on my birthday this year. It was a strange

day. I woke up in my home-based isolation habitat and when I got home later that day, returned it as well. I got to see my family and friends electronically, including those I live with. My direct interactions were at the hospital with colleagues and patients through gowns, gloves and face shields. But this is the “new normal.” That day, four of our patients with COVID-19 successfully completed their inpatient stay and discharged to home or to a rehabilitation facility. Among them was my first COVID-19 patient, the sweet elderly lady. It felt so good to be at work. Their success inspired me and gave me hope.

You see, the COVID-19 pandemic set the stage for critical scientific discussions and a collaborative, multidisciplinary approach to care. It has enabled us to lean on those around us when we needed it the most and prop up those who needed it. The view from the front line was not a monster without hope, but that of the team working together to bring the best care for my first patient with COVID-19.

Carole Freiburger-O'Keefe, DO

Critical Care Medicine

Saint Luke's Hospital of Kansas City

For the past two and a half months, I have worked with patients admitted to the COVID-19 ICU at Saint Luke's. I saw the reports coming out of Italy and my jaw dropped. As we prepared to receive the onslaught as was the trend from New York to Seattle to California, the anxiety started to mount. Would I be safe? Would I be able to handle the volume of critically ill patients? Would I be able to do my best—for my patients, for my family and for myself? With a disease process that was not well understood, the task at hand seemed daunting. But as the past few months unfolded, I feel honored and proud at what has transpired.

Our hospital leadership sprang into



Carole Freiburger-O'Keefe, DO, center, in the Saint Luke's COVID unit with multidisciplinary team members Jessica Koprovica, APRN, left, and anesthesia resident Cole Wrisinger, MD, right. She is holding a poster recognizing April as National Donate Life Month given to them by the Midwest Transplant Network. Under their head coverings they are wearing powered air-purifying respirators (PAPRs), pulled above their faces for the photo.

action. We already had measures in place from previous disaster preparation. We had a dedicated unit ready for an infectious disease outbreak that had been developed for Ebola. While we never had to use it for that purpose, it was ready. Our leadership met multiple times a day to ensure best practices for us. We had a core group of 6-8 intensivists including myself. When we finally started to admit patients who were suspected COVID-positive or who had actually tested positive, we were ready.

One of the biggest challenges was learning an entirely new disease process in real time. Information was sparse at first. Piles of journal articles were being published with preliminary data, some of which later proved to be wrong. Medication regimens, early versus late intubation, proning and steroids all seemed to take 180 degree turns. We took lessons from those who were experiencing the pandemic with a two-week head start. Mostly we pursued what seemed to work. We were part of the trial for convalescent plasma. We revamped our Code Blue practices to keep our health care workers safe.

COVID-19 is an awe-inspiring force to be reckoned with. It was pretty eye-opening to see how sick these patients get and how strong this virus is.

Saint Luke's chose to re-deploy employees in order to maximize our efforts. With the operating rooms filled with emergent cases only, the anesthesia assistants and CRNAs joined our COVID team. Nurses, physical therapists and respiratory therapists created a dedicated prone team to turn our COVID patients face down to better aerate their lung fields. Working with a wide group of health professionals—nurses, RTs, APPs and pharmacists—created a feeling of comradery and pride in our process.

The lack of family at bedside also proved to be a challenge. As we moved away from early intubation, patients were awake longer, self-proning when they could tolerate it. We saw a lot of anxiety and fear. Many would FaceTime their families on their own phones. For others, we had tablets in order to connect visually with families. Sometimes the barriers of technology precluded this. For the very sick, who were there on average of three weeks or more, daily phone calls by the team were the only way families could stay connected.

(continued on pg. 29)



Building Equity in Kansas City's COVID-19 Recovery

COMMITMENT NEEDED TO ELIMINATE HEALTH INJUSTICES AND ADVANCE HEALTH AND ECONOMIC PROSPERITY FOR ALL

By Qiana Thomason

Dedicated partners throughout our region have responded to the immediate needs presented by the rising number of COVID-19 cases and increasing economic turmoil with generosity, collaboration and creativity. In the coming weeks and months, we have an opportunity to harness that community commitment to illuminate health injustices exacerbated by the pandemic, advance awareness of existing inequities, and work together to advance health and economic prosperity for all.

Unfortunately, but not surprisingly, the impact of COVID-19 is not felt equally across the Kansas City region. As the virus ripped through our communities, it exposed deep inequities that determine whether people have necessary resources to be healthy. As health care workers, physicians, non-physician practitioners, researchers, payers and funders, the pandemic reminded us how vitally important are the social determinants of health, particularly for people of color who, in the pandemic, were more likely to:

- Lack insurance coverage, which has a direct impact on access to health care
- Have underlying health conditions that placed them at greater risk of severity and mortality from the virus, like asthma, sickle cell, lupus, diabetes and other chronic conditions
- Have significantly less income and assets to stay afloat after job loss or furlough
- Be in the essential services workforce, making social distancing requirements unattainable.

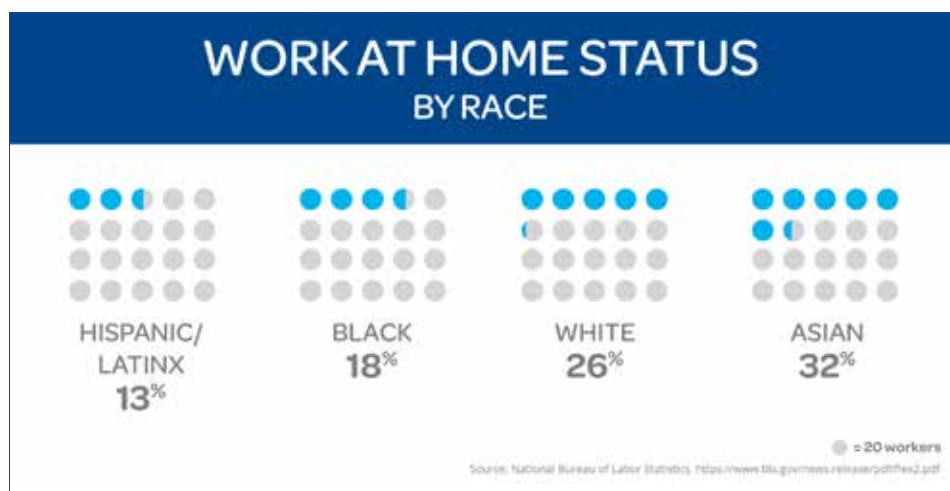


Fig.1

These data reveal that social distancing is unattainable for many black and brown people who comprise the essential services workforce.

A recent National Bureau of Labor Statistics report¹ found that only 13% of Hispanic and Latinx employees and 18% of black employees were likely to work at home, as compared to 26% of white employees and 32% of Asian employees. These data reveal that social distancing is unattainable for many black and brown people who comprise the essential services workforce (Fig. 1).

There's an adage in the black community that says, when America catches a cold, black people catch pneumonia. Available race and ethnicity data give credence to this adage. As of June 1, the Kansas City, Mo., Health Department reports that black

residents comprise as much as 37% of the confirmed cases in Kansas City, Mo., but represent 29% of the city, while Latino residents make up 24% of positive cases but represent 10% of the city.² In Johnson County, Kan., current data suggest that 10% of confirmed cases are black residents, while black residents comprise only 4% of the county.³ While black residents make up 22.5% of Wyandotte County's population, just over half of COVID-19 deaths are among black people.⁴

We applaud efforts by Kansas and Missouri to publish available data about confirmed COVID-19 cases by race and ethnicity. Yet, review of these regional

statistics highlights an important concern: too much data is missing. In Missouri, as of June 1, 17% of COVID-19 cases are of unknown race, and 25% are of unknown ethnicity. In Kansas, 19% of cases are of unknown race, and 18% of cases are of unknown ethnicity. This incomplete data inhibits our ability to address the long-term health and economic recovery of our states through an equity lens.

BUILDING EQUITY INTO RECOVERY

If there is a bright side to the challenges we face right now, it is that it provides an opportunity for a reset.

Health Forward Foundation is dedicated to eliminating disparities in our communities that are most in need. In response to the COVID-19 crisis and its unanticipated impacts, Health Forward reserved \$3.7 million to support stabilization and recovery in our service area. Emergency funding is focused on supporting the stabilization of the safety net health care and behavioral health systems; supporting testing, contact tracing and wrap-around case management services to individuals and families needing to self-isolate due to exposure; and providing essential services for vulnerable populations such as child care services for low wage essential workers and food assistance for communities in need.

We also joined funders from across the region by contributing to the Kansas City COVID-19 Regional Rapid Response and Recovery Fund administered by the Greater Kansas City Community Foundation. We are proud to be part of a philanthropic community that has acted quickly to help meet basic needs and stabilize our communities. But the vigor of that response does not alleviate the need for action from our public, private and government partners. There is a limit to what philanthropy can do alone to rebuild our communities.

What we need now are the unique strengths of every sector in our society

What we need now are the unique strengths of every sector in our society working together not just recover from the crisis, but to redesign a system that applies a racial equity and a health justice lens to all policies, practices and decision-making at community, organizational, corporate and policy levels.

working together not just to recover from this crisis, but to redesign a system that applies a racial equity and a health justice lens to all policies, practices and decision-making at community, organizational, corporate and policy levels.

To this end, Health Forward asserts the following as low-hanging fruit:

Reducing health injustices and achieving equity must be declared as an explicit goal of our “new normal.”

In reality, normal wasn’t working for everyone. As we move forward, equity must be central to recovery strategies and new solutions with specific goals, measures and metrics.

Collecting, analyzing and reporting data on health injustices is critical to improving outcomes.

In order to achieve health equity, we need to know where we are and how far we

are from our goal. Collecting data and developing metrics specific to health injustices and their underlying causes will allow us to track progress, hold ourselves accountable and reshape narratives

Health Forward and partners have urged both Gov. Laura Kelly in Kansas and Gov. Mike Parson in Missouri to leverage their influence to ensure that all health institutions and public and private laboratories standardize, collect and report to their respective health departments COVID-19 testing rates and results, contact tracing, hospitalization and mortality rates—disaggregated by race, ethnicity and ZIP code. States such as Oklahoma, Massachusetts, Vermont and Delaware—led by both Republican and Democratic governors—have already taken action to require similar data collection and reporting.

***Editor’s Note:** KCMS and the KCMS Foundation were among 75 community organizations from across the metro area that co-signed an April 27 letter from the Health Forward Foundation to Missouri Gov. Mike Parson and Kansas Gov. Laura Kelly requesting that state and local health departments prioritize the collection of COVID-19 data by race, ethnicity and ZIP code.*

Adequately funding our public health infrastructure and expanding Medicaid is necessary to increase access to care.

Many people of color and those living in poverty rely on our safety net medical, behavioral health and oral health centers for preventive and treatment services. Both Kansas and Missouri must prioritize right-sizing funding to public health departments and safety net providers. Further, expanding Medicaid to increase access to care was the smart thing to do from a health and economic perspective before the pandemic and is the obvious path forward in recovery.

Addressing racism in health care and the complex social determinants of health at the point of care.

Compared with whites, people of color are less likely to receive preventive health services and often receive lower-quality care. They also have worse health outcomes for certain conditions. To combat these health injustices, health care professionals must explicitly acknowledge that race and racism factor into health care and actively address it. The Institute for Health Improvements (IHI's) white paper, *Achieving Health Equity: A Guide for Health Care Organizations* offers actionable steps health care organizations can take to improve health equity in care delivery and in the communities they serve.

Further, the social determinants of health (e.g., socioeconomic factors, health behaviors, environment, etc.) are now widely recognized in health care as influencing up to 80% of health outcomes. Thus health care payment, policy and care delivery must include social determinant of health screening, coding, intervention and evaluation as standard best practice. To ensure success, new payment and care delivery models must prioritize partnerships with the social services sector and shift paradigms to engage these partners as key players in the health care ecosystem.

Communities impacted by health injustice must be included in the development of solutions.

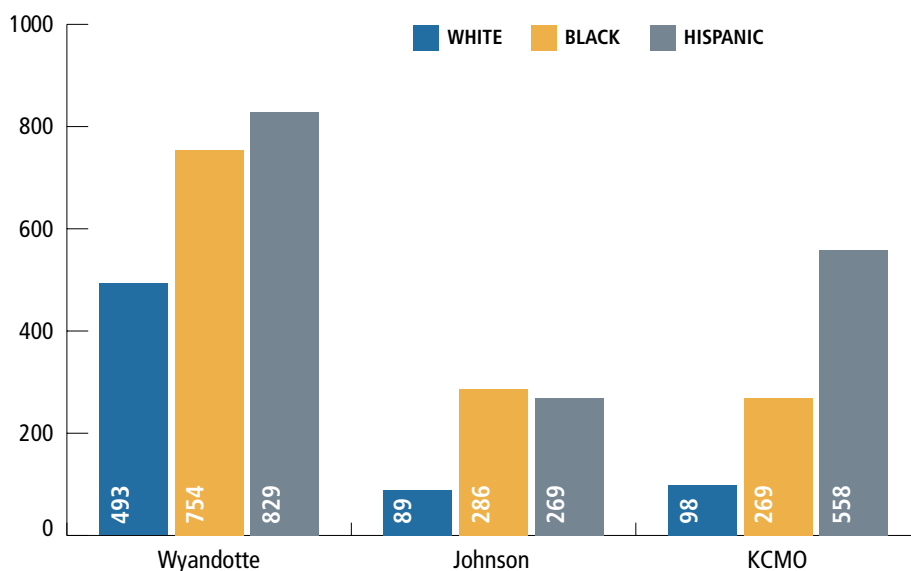
Far too often, plans are made by others for communities that live in marginalized conditions. Equity-centered planning, implementation and evaluation of solutions must be done “with” and not “for” those impacted.

Through these and other equity-centric actions, we can fortify our communities and do more than simply recover. We can

We can use the urgency of the pandemic to create the conditions in which everyone thrives and has a fair and just opportunity for health and well-being.

COVID-19 CASE RATES BY RACE AND ETHNICITY, PER 100,000 POPULATION

As of June 1, 2020



Source: Local health departments and *Kansas City Medicine* calculations.

use the urgency of the pandemic to create the conditions in which everyone thrives and has a fair and just opportunity for health and well-being.

To our grantees, medical providers and essential health care workers, thank you for the incredible work you do to advance the well-being of our community. It is needed now more than ever. We understand that you are facing unprecedented challenges brought on by the virus and the lingering financial impact on hospitals, clinics and practices.

We are proud to be part of this region. We are seeing organizations, corporations, funders and grassroots organizations unite in unique ways. We have witnessed the re-

silience of our communities. We know that through shared commitments to equity, we will rise stronger. ☺

Qiana Thomason is president/CEO of Health Forward Foundation. She previously served as vice president of community health and health equity at Blue Cross and Blue Shield of Kansas City. She can be reached at qthomason@health-forward.org.

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COVID-19: Changes and Challenges

AREA HOSPITAL CHIEF MEDICAL OFFICERS DISCUSS KEY TRENDS OF THE PAST FEW MONTHS AND WHAT'S AHEAD

COVID-19 has brought major changes and challenges across health care, ranging from how to care for infected patients while protecting the safety of non-infected patients and staff, to the loss of patients and revenue from the canceling of non-urgent care. Chief medical officers of six area hospitals shared their thoughts on what has occurred and what the future may hold with Kansas City Medicine. Some responses have been edited for length.



Larry Botts, MD

ADVENTHEALTH SHAWNEE MISSION

How have Kansas City-area hospitals coordinated with each other during the pandemic?

The majority of chief medical officers in the Kansas City region have participated in calls twice a week arranged by the University of Kansas Health System. These have been incredibly helpful because we get to discuss issues as they arise and learn what others in the region have been doing. Our collaboration ensures local health care providers have consistent messaging and policies, making things easier for our communities.

How quickly will non-urgent care ramp up? How concerned are you about patients not returning due to COVID-19 fears?

Ramp-up of non-urgent care is going to be determined by the public's comfort with coming back to health care entities. It is safe for everyone to return, and we encourage people to seek out medical care when they need it, because this is a better alternative than putting things off. I am concerned about secondary health issues. We've already seen patients delaying

emergency care and experiencing acute conditions that could have been prevented, and long term we may see the effects of patients delaying physicals and specialist appointments and therefore missing new diagnoses like high blood pressure and blood sugar issues. Caught early, we can manage these, but if they go undetected for long periods of time they can cause significant long-term health problems.

How are you preparing for a second wave of infections?

We have all of the processes in place to handle a second wave if there is one. We were prepared for a far greater surge in patients than we actually experienced, and those plans can be activated if needed in the future. I am optimistic that it won't occur now that we are taking precautions to prevent the spread of disease.

What permanent changes do you see this bringing to the health care system?

I would prefer to see no permanent changes; long term I don't anticipate a lot of changes. I do think we'll see increased

utilization of telehealth and we may see daily temperature checks at daycares and nursing homes for the long term.

Given the financial stress on hospitals, has this led (or could this lead) to a loss of available talent and services?

There has certainly been a great impact on hospitals and independent physicians, but I don't anticipate seeing talent and service impacted long term.

How is your hospital viewing physician practice acquisition at this point in time?

We would still consider physician practice acquisition as we normally would, and would evaluate any opportunity that may make sense for our organization.

What new wellness initiatives or education efforts have been introduced as a result of the pandemic?

It's not new to us, but our physician well-being program was critical for helping providers manage their stress and emotions throughout the pandemic. This program includes free mental health consultations for our providers and many resources dedicated to reminding them to take care of themselves. We've certainly seen new community education efforts on handwashing, social distancing and guidance on reopening public spaces that will continue.



Olevia Pitts, MD

RESEARCH MEDICAL CENTER

How have Kansas City-area hospitals coordinated with each other during the pandemic?

Kansas City hospitals have been sharing through a number of leadership and physician professional organizations during this pandemic. The learnings we share potentially benefit patients, employees and the communities we serve. We have also coordinated with several universities and colleges to continue to offer didactic and revamped simulation experiences so future physicians and nurses can continue their education.

How quickly will non-urgent care ramp up? How concerned are you about patients not returning due to COVID-19 fears?

I'm most concerned about people NOT seeking out the lifesaving care they need. Recognizing the symptoms of stroke and

heart attack are as important now as ever. When necessary, 911 services should be utilized. We have a robust telehealth program for routine and non-urgent medical concerns. Patients and physicians are scheduling non-emergency surgery. These patients are coming back, and we are assuring them of all the measures we are taking to keep them and their families safe.

How are you preparing for a second wave of infections?

We prepare constantly, and now that we have some experience with COVID-19, we know we must remain vigilant to safety precautions. We closely monitor our resources. Being part of HCA Healthcare allows our supply chain to allocate resources appropriately based on need in our market and division as well as across the enterprise.

What permanent changes do you see this bringing to the health care system?

Rapid testing comes to mind. We have one platform currently. It has made a big difference in patient care and outcomes. In addition, patients are already becoming more comfortable with tele-services. HCA Midwest Health quickly made urgent care and specialty care physician visits easily accessible. Our physicians are seeing patients in their offices and in new, creative ways. We are maintaining our depth and breadth of many levels of health care services at this time.

What new wellness initiatives or education efforts have been introduced as a result of the pandemic?

Maintaining health is even more important now. HCA Midwest Health and Research Medical Center have offered wellness visits and health education for years. I think this pandemic brings physical and behavioral health to the forefront.



Mark Steele, MD

TRUMAN MEDICAL CENTERS

How have Kansas City-area hospitals coordinated with each other during the pandemic?

The goal of communication between medical centers is to increase situational awareness and to share both best practices and concerns. To make sure this happens, the Mid-America Regional Council (MARC) Healthcare Coalition leadership conducts a weekly webinar on Mondays. The hospitals also make weekly calls to each other, with and without public health

officials. In addition, there has been an open line of communication between CEOs, CMOs and CNOs to share best practices.

How quickly will non-urgent care ramp up? How concerned are you about patients not returning due to COVID-19 fears?

Truman Medical Centers/University Health is open and prepared to care for its patients. We have taken specific steps to ensure the health patients and staff.

We are screening all staff and patients for COVID-19 symptoms, and we continue to wear masks in the medical center. Other steps include a strict visitor policy, practicing social distancing in waiting rooms and sanitizing frequently touched surfaces.

How are you preparing for a second wave of infections?

Hospitals continue to look at ways of adding bed capacity. Most are also continuing to implement measures to extend the useful life of disposable items. They continue to purchase PPE, hand sanitizer and other supplies. We are purchasing additional powered air-purifying respirators (PAPRs) units and ventilators. *(continued)*

TRUMAN MEDICAL CENTERS

*(continued)***What permanent changes do you see this bringing to the health care system?**

This pandemic will force us to re-evaluate how we see patients and could change how our talent performs their work. For example: virtual assessments, office visits and telehealth. Being innovative will help retain our talent.

Given the financial stress on hospitals, has this led (or could this lead) to a loss of available talent and services?

The health care talent we need is being more conservative than ever in considering a job change given the unknown state of what COVID-19 will do in the months to come. If necessary, we will recruit nation-

wide in areas which have been hit hardest by COVID. Health care providers in those areas may find our part of the country to be safer. But we are aware that there will be career changes for some health care workers due to fear of exposure.

How is your hospital viewing physician practice acquisition at this point in time?

Based on the time and financial commitment it takes for physician education and training, we have not seen nearly as much impact as other jobs in health care.

What new wellness initiatives or education efforts have been introduced as a result of the pandemic?

Allowing our team to maintain their mental and physical wellness continues to be a priority. To make sure staff has

access to the tools it needs, our wellness team switched from the traditional gym, personal training and fitness class model to other strategies. These include providing online exercise and stretching videos, opening up rehab departments for individual use of exercise equipment, encouraging use of the employee assistance program, and implementing a 404-TALK program.

To continue to be able to communicate well with staff working remotely, we implemented the use of ReGroup, an app that sends the most updated information and education to users' mobile devices. To ensure we were able to celebrate the hard work of our staff, we implemented a "Heroes Program" that allows staff to send an electronic card to a worker or department expressing gratitude and encouragement.

*Steve Stites, MD*

UNIVERSITY OF KANSAS MEDICAL CENTER

How have Kansas City-area hospitals coordinated with each other during the pandemic?

Early in the pandemic, The University of Kansas Health System reached out to physicians and executives in China and New York City as well as the Centers for Disease Control to gain insight into the COVID-19 disease process and best practices for treating, testing and mitigating. Here in the community, the chief medical officers from area hospitals participate in joint calls two and three times a week to learn from one another and create surge plans. Similarly, intensive care unit specialists talk regularly to keep tabs on supplies including medication and ventilators. Our lab specialists have also worked interna-

tionally and locally to increase specimen collection and testing capacity.

How quickly will non-urgent care ramp up? How concerned are you about patients not returning due to COVID-19 fears?

We are back to scheduling and performing all surgeries and procedures, including general anesthesia and elective. Currently, patients are required to be tested for COVID-19 at around 48 hours before any scheduled surgery or procedure. We are working hard to help patients understand they are safe to receive care as we have strict measures in place to screen for COVID-19 as well as keep patients and staff safe when here. Patients, in turn, are asking great questions. While some have

fears related to COVID-19, we've had more patients say they are reluctant to have the nose swab for specimen collection because they are afraid it will hurt. Our census is growing each day as patients need and want care.

How are you preparing for a second wave of infections?

We are not nearly out of the woods yet. We continue to build our stores of PPE and medications used to offer COVID-19 patient care. We also keep close tabs on the number of ventilators in use and available. Our emergency plans remain in place, and our communication teams continue to put out daily updates on pandemic-related operations.

What permanent changes do you see this bringing to the health care system?

Necessity is the mother of invention, and the pandemic has led to critical changes that have made our *(continued on pg. 20)*



Area Physicians on the Front Lines

(clockwise from top left) Emergency physician Sara Cross, MD, in her PPE at AdventHealth Shawnee Mission (photo courtesy AdventHealth). Stephen Eikermann, DO, critical care physician, preparing to see patients at Truman Medical Center (photo courtesy Truman Medical Center). Anesthesiologist Shea Stoops, DO, in the operating room at the University of Kansas Hospital (photo courtesy The University of Kansas Health System). Getting ready for a happy patient send-off from Research Medical Center are, from left, hospitalist John Armilio, MD; recovered COVID patient Sharon Davies; and infectious disease physician Marjorie Wongsakhaluang, MD (photo courtesy Research Medical Center). Hospitalist Chris Brown, MD, between patients in the COVID-19 ward at the University of Kansas Hospital (photo courtesy The University of Kansas Health System).

UNIVERSITY OF KANSAS MEDICAL CENTER (continued)

health care safer and nimbler. Telehealth is a leading example. We stood up our program in two weeks which was planned to phase in over two years. We acquired licenses, cameras and headsets for 2,500 clinicians and schedulers to help provide a continuum of care to our patients. Telehealth has proven effective, and patient surveys show they like the access and the visit. Between March and May, physicians conducted more than 48,000 telehealth visits and counting.

During this pandemic, correct information is as critical as the care we give. People need the right information to protect themselves and guidance on when to seek care. Using the power of our Dolph C. Simmons, Jr., Family Broadcast Studio, the health system created *Take Ten* and the *Morning Media Update* ... two new daily programs which allow us to quickly stream internal and community information and respond to questions. The communication is effective and will live on in some form long after

the pandemic is past. Internally, the studio has also served as a safe place for regular, live updates for physicians and nurses; these programs will also likely live on.

Given the financial stress on hospitals, has this led (or could this lead) to a loss of available talent and services?

The University of Kansas Health System is approaching the financial stress caused by COVID-19 perhaps differently than some hospitals. We have no plans to reduce staff, as our employees are highly trained with services in high demand. We believe it would be short-sighted to part with medical and support staff when we need them most. We are looking at where we tighten our belt with costs that do not impact patients. We are applying for relief funds to help offset the costs we are incurring directly related to COVID-19. And, we are working hard to get our patients back to the doctors' offices and back to the operating room in a way that keeps them and our staff safe.

How is your hospital viewing physician practice acquisition at this point in time?

We are evaluating new talent through the lens of necessity and using virtual meetings to recruit and retain.

What new wellness initiatives or education efforts have been introduced as a result of the pandemic?

Perhaps not new, but expanded and emphasized, are resiliency efforts to address the mental as well as physical health of employees from physicians and nurses to support staff. Access to these resources is shared in daily corporate and physician briefings that are emailed directly to all employees and/or doctors. I have also reflected many times during this pandemic how much safer COVID-19 is making health care and personal care. Everywhere I go, I see people coughing into their elbows, washing and sanitizing their hands. In truth, I'd like to see more people wearing masks and practicing greater physical distancing, but these best practices that are employed by infectious diseases experts are becoming more the norm at home and in public. This will make us all safer against COVID-19, flu and other viruses.



James Stewart, MD

NORTH KANSAS CITY HOSPITAL

How have Kansas City-area hospitals coordinated with each other during the pandemic?

I have participated in a bi-weekly discussion with chief medical officers from local hospitals, and our CEO has stayed in close communication with local hospital CEOs through the Missouri Hospital Association's Kansas City group. Additionally, our infectious disease physicians have consulted peers throughout the region.

Members of our organization have also joined the Mid-America Regional Council's Hospital Coordination Committee planning calls.

How quickly will non-urgent care ramp up? How concerned are you about patients not returning due to COVID-19 fears?

We plan to continue ramping up ambulatory care and non-urgent surgeries in phases outlined by health experts and the

American College of Surgeons. Recently, we began scheduling outpatient services and non-urgent surgeries. While some patients were initially hesitant to return to the hospital for less emergent care, patients have become more comfortable since cities began reopening.

How are you preparing for a second wave of infections?

The policies and procedures we put into effect for the initial outbreak will remain in place. As such, we're prepared for a second wave of infections.

What permanent changes do you see this bringing to the health care system?

NORTH KANSAS CITY HOSPITAL

(continued)

COVID-19 has changed the health care system in many ways, but one of the biggest changes I anticipate is how and when we utilize telehealth. This pandemic is also likely to permanently change how we screen admissions.

Given the financial stress on hospitals, has this led (or could this lead) to a loss of available talent and services?

We've been fortunate enough to have the continued support of our existing physicians and staff throughout this crisis.

While the pandemic has temporarily affected long-distance recruiting, we have been able to continue onboarding new talent throughout these challenging times. Regarding service offerings, we faced the same challenges as other providers. To help reduce the spread of infection, we initially suspended non-urgent surgeries and restricted outpatient services. However, to meet the needs of our community, we've begun ramping up outpatient service appointments and non-urgent surgeries with the guidance of health care experts.

What new wellness initiatives or education efforts have been introduced as a result of the pandemic?

Educating staff, patients and the surrounding community about infection prevention has been of the utmost importance. We've also focused on mental health issues because we know how closely tied mental well-being is to physical health.



James Wetzel, MD

OLATHE HEALTH

(Retired as of June 5, 2020)

How have Kansas City-area hospitals coordinated with each other during the pandemic?

There has been an extraordinary degree of cooperation. The CEOs and chief medical officers in the metropolitan area have been invited to participate in roundtable calls. Information has been shared on the number of COVID-19 inpatients, the number on ventilators and the various treatment options selected. In addition, the availability and use of personal protective equipment has been shared. Testing and results of testing are shared as is bed availability. Most importantly, this has been a great way to dispel rumors.

How quickly will non-urgent care ramp up? How concerned are you about patients not returning due to COVID-19 fears?

Each of our facilities is reporting a gradual return toward normal. Addition-

al steps required in facilities will likely prevent return to 100% of previous volume in the near future. Ambulatory care has increased, with scheduled visits increasing more rapidly than emergency department or urgent care visits. On the other hand, the number of acute myocardial infarctions presenting for care and even new cancer cases have decreased since this began. Those two facts suggest that necessary care is being delayed out of fear. All hospitals and clinics have put into place safety measures so it is safe to visit your provider for necessary care.

How are you preparing for a second wave of infections?

All facilities planned for surges of patients during the first wave of infection. This included adding additional beds, assuring that adequate supplies of PPE were in stock and that the staff had been

trained to safely care for patients. Facilities now screen all staff and visitors for symptoms and fever. All this prepares us for a second wave. Processes and protocols will remain in place; we all will be monitoring COVID-19 activity in our facilities and communities. We will have additional supplies of personal protective equipment, IV tubing, drugs and IV fluids at stock levels higher than in the past.

What permanent changes do you see this bringing to the health care system?

Much like universal blood precautions that were brought about by HIV, we now will likely continue social distancing, droplet protection by face masks and face shields as well as screening for illness. Our waiting rooms and cafeterias will have fewer chairs, we may never return to the unlimited visitor policy we had in the past, and for the foreseeable future will continue a robust COVID testing strategy.

Given the financial stress on hospitals, has this led (or could this lead) to a loss of available talent and services?

At the time COVID-19 arrived, none

of us could foresee that hospitals would be treating fewer patients. The loss of eight weeks of elective surgery, coupled with the downturn in office and imaging visits, has been devastating financially to all hospitals. Adding to that is the disproportionate number of COVID-19 cases affecting the poor and uninsured. Most health systems have cut back on staff and some on services, all in the attempt to remain financially solvent. Hospital systems have high fixed costs and operate at slim margins, so when business is down 50% and expense remain at nearly 100%, losses ensue.

How is your hospital viewing physician practice acquisition at this point in time?

Our facility has been in the physician employment business since the late 1980s and has acquired many practices over the years. We remain open to adding services necessary to meet the needs of our community.

What new wellness initiatives or education efforts have been introduced as a result of the pandemic?

Much education has occurred around proper use of personal protective equip-

ment including proper donning and doffing of masks, gloves and gowns to assure safety of our associates and patients. We have educated staff about COVID-19 in the community. The community has been generous with donations and with cards of thanks to our frontline workers. We are all very grateful for the support.

KCMS Foundation Appoints Karole Bradford Chief Executive Officer



The Kansas City Medical Society Foundation has named Karole Bradford as chief executive officer effective

May 1, 2020. Bradford

joined the KCMS Foundation in December 2018 as chief program officer and since then has overseen its staff and operations.

With nearly 20 years of nonprofit leadership experience, she previously was executive director of Riverview Health Services, a Kansas City, Kan., agency that helps uninsured children and adults access prescription medications. Her background includes 11 years of experience in Wyandotte County safety net health care. She holds a bachelor's degree from Wichita State University.

Bradford succeeds Angela Bedell, MA, CAE, who has been executive director since 2018 when the KCMS Foundation was formed through a merger of the Wy Jo Care and Metro Care charitable care programs for the uninsured. Bedell continues as executive

director and CEO of the Kansas City Medical Society and will work closely with Bradford on matters involving the KCMS Foundation and the Medical Society.

"We are pleased to have an individual with Karole's talent and experience to lead the KCMS Foundation through its next steps of growth and development. Over the past year, she has proven herself very capable of leading the KCMS Foundation's staff and operations," said Stephen Salanski, MD, chair of the KCMS Foundation board of directors.

"In addition, we salute Angela for her outstanding leadership in shepherding the merger of the Metro Care and Wy Jo Care charitable care programs into the KCMS Foundation. This was a lengthy and complex process that has yielded a strong organization better positioned to help meet the health care needs of the many uninsured, low-income residents of the Kansas City area—a need now intensified by COVID-19," Dr. Salanski continued.

The KCMS Foundation advances health care access for vulnerable populations in the Kansas City metropolitan area. Its charitable care programs—Wy Jo Care in Kansas and

Metro Care in Missouri—connect uninsured, low-income individuals with specialty medical care they otherwise could not afford. Participating physicians, hospitals and other health services donate care free of charge to these patients out of their concern for the less fortunate. In 2019, Wy Jo Care and Metro Care served nearly 800 patients and arranged for more than \$8,000,000 in donated medical care. Besides charitable care, the KCMS Foundation conducts wellness and prevention initiatives, coordinates a coalition promoting health care workforce diversity, provides community health education and currently is advocating for Medicaid expansion in Missouri and Kansas. ☺

Q&A With KDHE's Lee Norman, MD

KCMS member Lee Norman, MD, has been leading Kansas' public health response to the COVID-19 crisis. He joins with Gov. Laura Kelly for regular press briefings, and hosts a weekly Q&A session just for kids. Dr. Norman was appointed Kansas secretary of health and environment in January 2019. He previously was senior vice president and chief medical officer of the University of Kansas Health System. He took a few minutes with Kansas City Medicine to answer our questions.

What lies ahead for Kansas City in the next 6-12 months in the COVID-19 crisis?

I think we are going to get a bit of a reprieve during late spring/summer and then a resurgence in the fall/winter. The metro area responded well in the first round, and I think we will be better positioned with PPE and plans in place to anticipate the second wave. Ideally, this would mean not having to cut back so severely on routine and elective care.

What are some public health lessons learned so far from COVID-19?



Facebook graphic promoting Dr. Norman's media briefings.

I think there are many lessons we have learned thus far from COVID-19. First and foremost, the reminder of the chronic underfunding of public health. Additionally, the critical importance of immunization and drive towards herd immunity through vaccination is another key lesson. COVID-19 has also caused us to take a fresh look at our supply chain and the many dependencies that exist, some of which were surprising to us. Finally, technology has not been maximized for contact tracing in what will become a more modern approach to contact tracing/people movement.

What steps and investments need to be made to improve our public health system so we are more ready for the next pandemic?

COVID-19 points out the need to look at novel situations and do simulations/

exercises to understand where our vulnerabilities lie. While state and local entities participate and plan different emergency exercises, COVID-19 has shown the importance of independent health care providers, hospitals and other businesses also preparing and planning for the unthinkable. We also need to make improvements with interagency linkages, many of which did not go smoothly.

Are there other comments you would like to share with our readers?

You own your own preparedness. Its critical people take preparedness seriously and understand how to mitigate risks. 😊

Outreach Efforts Promote COVID Testing Among Minorities



Outreach efforts are underway in Missouri and Kansas to provide COVID-19 testing to underserved populations.

As part of its mobile outreach, Truman Medical Centers and University Health have been conducting testing in eastern Kansas City as well as other parts of Jackson County since April.

In Wyandotte County, initial data showed a very low incidence of COVID among Hispanics, indicating that they were not being reached by testing. As a result, the Unified Government Public Health Department in May formed a Health Equity Taskforce to address this issue. This group includes churches, community centers, advocacy groups, community health centers, the University of Kansas Medical Center and more. Since May, the Health Equity Taskforce has been conducting testing at sites in underserved neighborhoods and greatly increased the number tested.

(Left) Truman Medical Centers conducted this COVID-19 mobile outreach testing at Highland Missionary Baptist Church in Kansas City, Mo., in April. (photo from Truman Facebook page)



The Invisible Wounds of COVID-19: The Mental Health Crisis in Health Care Workers

PANDEMIC BRINGS NEW RISKS AND FEARS

By Craig Pearson, PhD, and Jessica A. Gold, MD, MS

Since the start of the coronavirus pandemic, the mental health of health care workers has been at risk. Many found themselves facing novel threats to their personal safety and the safety of those around them—threats that were often drastically different from those they had previously faced in their daily lives and work.

This mounting awareness of danger early in the pandemic was compounded in many cases by medical workers' lack of access to personal protective equipment (PPE).¹ On top of this, as the virus spread across the world, the nature of the day-to-day work on the ground changed almost overnight. In addition to the regular job stressors, health care workers were dealing with higher than normal reported rates of patient deaths, pervasive fear of the unknown, disagreement regarding best treatment practices, the absence of patients' families on the units, and fears of needing to ration or allocate resources like ventilators or medications, that in many cases did not materialize.²

These challenges arrived against a backdrop of physician wellness that was already compromised. Medical students and residents have rates of depression much higher than the general population,^{3,4,5} and physician suicide is among the highest of any profession.⁶ Physicians also have high rates of burnout across the spectrum, up to 50% in many studies, which has been shown to affect

productivity, patient care, and, of course, personal mental health.⁷ One study estimated that the annual productivity lost due to physician burnout is equivalent to the loss of seven medical school graduating cohorts.⁸ Despite this, many physicians do not receive mental health care or ask for help when they need it. In many cases, they avoid it.^{9,10}

CURRENT STRESSORS

As the pandemic has evolved, so have the stressors. The impact of the novel coronavirus has affected different regions in different ways—whether because of differing caseloads or the financial impact of COVID-19 on medical practices. Hospitals readied themselves to look like Wuhan or Northern Italy or New York City, reassigning staff to perform urgently needed tasks and procedures which, in some cases, they had not practiced in years,^{11,12} and preparing wards for an expected surge of COVID-19 patients. But the expected crises did not manifest everywhere in the same ways. Cities locked down, unemployment rose, and patient appointments were cancelled, postponed, or made virtual. Medical research not directly related to the new coronavirus was almost universally stalled. This meant that even in regions with large COVID-19 patient volumes, hospitals were taking substantial financial hits and some employees were forced to take pay cuts.

Now, as cities reopen, patients fear

returning to medical institutions for routine or acute care,¹³ and it is becoming clear that medicine will be struggling for a long time and some hospitals and clinics might not survive.^{14,15} Many will suffer financial and administrative burdens for years to come. Thus, while not every frontline worker's mental health is directly affected by seeing the day-to-day care of COVID-19 patients who are dying at high rates, the risk of developing long-term mental health effects is still high, due to this broad spectrum of stressors.

Even if the worst case does not arise, the fear and anticipation of subsequent surges in COVID-19 cases will profoundly affect the mental health of frontline workers in the coming months and years. For instance, resources in regions with high caseloads, such as New York, were strained to the breaking point at the local peak of the pandemic, whereas elsewhere, like much of the Midwest, hospitals have largely managed to keep up with lower rates of community spread.¹⁶ For workers in these lower caseload areas, this creates a sense of anticipatory anxiety: Are we out of the woods yet? When will a fresh wave hit us? Will it ever come?

The uncertainty of the virus' spread among these populations, combined with alarming, often traumatic images shared by friends and peers on the harder-hit coasts, or throughout social media, can contribute to a sense of constant threat that impairs health care workers' ability



While not every frontline worker's mental health is directly affected by seeing the day-to-day care of COVID-19 patients who are dying at high rates, the risk of developing long-term mental health effects is still high.

to maintain focus and preserve their mental well-being. And, for the harder-hit regions that are now rebounding, the fear of a second or third COVID-19 surge contributes to unresolved anxiety. Until we have a more confident plan or treatment or vaccine, it is reasonable to expect that health care worker mental health will be at persistent, increased risk. Anxiety, after all, stems from uncertainty.

ADDITIONAL ISSUES

The coronavirus pandemic is not the only ongoing threat to mental health. We are currently in the midst of national political upheaval and civil unrest.¹⁷ While there is concern the widespread protests could lead to additional coronavirus cases, frontline workers must continue to work in the hospitals while doing their best to process the grief that many feel over the sociopolitical climate and, in some cases, a conflict between the wish to protest and the feeling of obligation to maintain recommended physical distancing practices. This also has potential to jeopardize the well-being of physicians, particularly black physicians, who are already taking care of COVID-19 patients who disproportionately look like them.¹⁸

While we do not have data about mental well-being in physicians by race, the existence of systemic racism

is readily observable, along with the fact that underrepresented minorities disproportionately work lower wage jobs, are less likely to have good workplace benefits, and are more likely to be in direct contact with COVID-19.¹⁹ High risk of infection is known to yield mental health effects in pandemics, and so this is overall an especially high-risk group that needs to be monitored.²⁰

It is impossible to predict exactly what the mental health outcomes will be after the pandemic. Preliminary data from China suggests that rates of PTSD, anxiety, and depression will be high.^{21,22,23} If we look at the data from past pandemics, it is also true that depression is possible, along with trauma and workplace avoidance,²⁴ but it is difficult to apply that data to the current moment. We can look to previous studies of imposed quarantine, such as SARS, to infer that those health care workers who do contract COVID-19 and undergo quarantine may be at high risk for depression, substance use and PTSD, even three years after the epidemic.²⁵

Yet, we don't know the impact of self-isolation as it has been adopted in 2020, and the scale of this pandemic is much different from those studied in the past. We do know that there are high risks of negative mental health outcomes among those who directly worked with

COVID-19 patients, those who contracted the illness or knew someone who did. Also at increased risk are women and those with previous psychiatric histories and substance use histories.²⁶ These groups should be regularly screened and closely monitored. Given the scale of the pandemic, it seems likely that we will be observing and dealing with its impact on health care workers' mental health for a long time. And the pandemic isn't even close to over.

ACTION STEPS

So, what can be done? Medical institutions have an obligation to support their staff's mental health for the long term and not just implement short term policies. Given the timeline of treatment and vaccine development, it is clear that this is not something that will go away soon. We need to figure out which measures that were put in place temporarily should stay around—hotlines, extra appointments, group therapy, crisis support—and which need to be altered. Not all policies have to be mental health related to help mental health. Institutions can safeguard their workers' physical health with PPE and workplace safety policies, or their sick leave or child care policies.

At the very least, we need to work to change the culture of medicine, to make it

Given the scale of the pandemic, it seems likely that we will be observing and dealing with its impact on health care workers' mental health for a long time. And the pandemic isn't even close to over.

one in which vulnerability and emotions are discussed, not hidden. Getting help should be safe and encouraged. We should not be asking on credentialing, licensing, or insurance forms for mental health histories, which only serve to discourage treatment seeking.²⁷ As a community in health care, it is up to us to finally approach these problems the way we approach the illnesses we treat in our patients—that is, with more than a bandage. A mental health crisis is looming for frontline workers, and we can't keep hiding behind patient care and stoicism for long. For many, the effects are already here.

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Workers' Mental Health." Her writings are available on her website, www.drjessigold.com. She can be followed on Twitter, @drjessigold. She can be reached at jgold@wustl.edu.

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Mental Health Resources

The COVID-19 pandemic has brought much added stress for physicians, residents and medical students—whether it be from caring for patients on the front lines, or from the disruption of their practices or educations. Here are several mental health resources:

- **The Missouri Physicians Health Program**, themphp.org, (314) 578-9574, and the **Kansas Medical Society-Professionals' Health Program**, kmsonline.org/php, (800) 332-0156, offer free, confidential consultation.
- **Physician Support Line**, (888) 409-0141, offers free and confidential peer support to American physicians by creating a safe space to discuss immediate life stressors with

volunteer psychiatrist colleagues. This service was launched in March 2020 to help physicians cope with the stress of COVID-19.

- **The American Medical Association** offers mental health tips for physicians, patients and staff, on its website, <https://bit.ly/ama-mental-health>.

Clinical Trials Under Way in Kansas City for COVID Treatments

As of June 7, there are 13 clinical trials underway in the Kansas City area for COVID-19 treatments and vaccines, according to the website clinicaltrials.gov:

Study of Open Label Losartan in COVID-19
University of Kansas Medical Center

Dapagliflozin in Respiratory Failure in Patients With COVID-19
Saint Luke's Mid-America Heart Institute

Awake Prone Position for Early Hypoxemia in COVID-19
University of Kansas Medical Center

The COVID-19 ICU PRAYER Study
Research Medical Center

Safety, Tolerability and Immunogenicity of INO-4800 for COVID-19 in Healthy Volunteers
Center for Pharmaceutical Research

NCI COVID-19 in Cancer Patients, NCCAPS Study
Truman Medical Centers, University of Kansas Cancer Center, Olathe Health

A Study to Evaluate the Efficacy and Safety of Tocilizumab in Hospitalized Participants With COVID-19 Pneumonia
University of Kansas Medical Center

Dose-Confirmation Study to Evaluate the Safety, Reactogenicity, and Immunogenicity of mRNA-1273 COVID-19 Vaccine in Adults Aged 18 Years and Older
Heartland Research Associates

Compassionate Use of Hyperbaric Oxygen Therapy
Providence Medical Wound Center

Healthcare Worker Exposure Response and Outcomes of Hydroxychloroquine
University of Kansas Medical Center

Evaluation of Activity and Safety of Oral Selnexor in Participants With Severe COVID-19 Infection
University of Kansas Medical Center

Phase III DAS181 Lower Tract PIV Infection in Immunocompromised Subjects (Substudy: DAS181 for COVID-19): RCT Study
University of Kansas Medical Center

Pharmacokinetics, Pharmacodynamics, and Safety Profile of Understudied Drugs Administered to Children Per Standard of Care (POPS)
Children's Mercy Hospital, University of Kansas Medical Center

Leading American Hospital Association



Melinda L. Estes, MD, president and CEO of Saint Luke's Health System, is serving as 2020 chair of the American

Hospital Association. She is the top elected official of the national organization that represents America's hospitals and health systems. A board-certified neurologist and neuropathologist and KCMS member, Dr. Estes has led Saint Luke's since 2011.

Practices Rapidly Expand Telemedicine During COVID-19

PHYSICIANS, PATIENTS ENJOY CONVENIENCE OF VIDEO VISITS; TEMPORARY PAYMENT PARITY MAKES TELEMEDICINE MORE FEASIBLE

By Jim Braibish, *Kansas City Medicine*



Screen shot of the April 26 NBC News story on telemedicine featuring Saint Luke's Hospital. Arthur McGhie, MD, of Saint Luke's Mid-America Heart Institute, left, conducts a telemedicine consultation with a patient.

As COVID-19 protective measures went into place in March and limited patient access to physician offices, practices quickly turned to telemedicine—the use of video or phone visits—to continue patient care.

Area health systems report that they have jumped from minimal telemedicine visits to up to thousands each month. Experts say growth of telemedicine—aided by the temporary easing of regulations and payment restrictions by Medicare, private insurers and states—is here to stay.

“We were doing very little, if any, clinical telemedicine prior to the COVID pandemic, aside from teleneurology,” said David A. Voran, MD, associate professor of informatics in the Department of Community and Family Medicine at the University of Missouri-Kansas City and Truman Medical Centers. “As government rapidly implemented COVID waivers that brought parity between face-to-face visits and video visits, and later telephony, this accelerated the use of telemedicine to

where at one point over 60% of all visits here were being conducted virtually.”

At The University of Kansas Health System, Keith Sale, MD, FAAAA, vice president and chief physician executive of ambulatory services, said, “Converting to telehealth video visits had been on our radar for several years, but a full rollout across all departments, physicians and providers was initially planned as a two-year phased rollout. As the pandemic hit Kansas City, we condensed that plan and went live with telehealth video visits in two weeks.”

Saint Luke's Mid-America Heart Institute was the subject of an April 26 NBC News story on the ramping up of telemedicine. Michael Main, MD, co-medical director of cardiovascular services for Saint Luke's, told NBC that Saint Luke's handled over 5,000 telemedicine visits in April, up from just 20 in the month prior to COVID.

“What COVID has forced us to do is innovate,” he said in the broadcast.

“As government rapidly implemented COVID waivers that brought parity between face-to-face visits and video visits, and later telephony, this accelerated the use of telemedicine to where at one point over 60% of all visits here were being conducted virtually.”

PUTTING EQUIPMENT AND PROCEDURES IN PLACE

Both the KU Health System and Truman/University Health are utilizing Zoom, which Dr. Sale noted has a HIPAA-compliant platform. The health system is adding over 600 video cameras and headsets, he added.

Along with the equipment, the health system “developed new workflows that incorporated changes in scheduling, pre-visit prep, clinician documentation, billing and discharge planning,” Dr. Sale said.

At Truman, a 70% drop in in-person visits the week of March 16 prompted a quick rollout of telemedicine, Dr. Voran said. By the following week, in-person

visits remained low but telemedicine far exceeded in-person. During the month of April, over 60% of visits were conducted virtually.

“Initially we tried to get as many patients scheduled virtually as possible while allowing them to choose a face-to-face visit. Within a week or two, we used what we learned to build a consistent process that could be used across the clinics,” Dr. Voran explained.

POSITIVES IN TELEMEDICINE

Both physicians agree that telemedicine offers many advantages, and the current COVID waivers on regulations and payment rules should be made permanent.

“We providers are now able to offer a more patient-driven, clinically appropriate

set of choices that benefit both the patient and the provider. Many clinical visits entail services that do not require hands-on physical exams and could just as easily be completed by video. Now, the patient and clinician can agree on the most appropriate type of visit for the problems being addressed,” Dr. Voran said.

Concluded Dr. Sale: “I really hope telehealth is here to stay. It is a tremendous service that prior to COVID was limited by restrictions and coverage. Our patients are universally loving it. Our physicians love it. Long term, this also remains a way to help reduce transmission of the COVID virus. We will need to figure out the optimal balance between telemedicine and in-person over time.”

For Dr. Voran, the move to

telemedicine is long overdue. “We’ve had affordable two-way digital video technology for over 20 years. But regulatory restrictions throttled our ability to use telemedicine. An analogy would be forcing people to order online from Amazon at an Amazon brick-and-mortar site. Would Amazon ever be successful under that kind of arbitrary limitation? Yet overnight, a pesky little virus brought about more change than any of us ever could imagine.” 🙄

FRONT LINES

(continued from page 11)

My family has been incredibly supportive. Despite having two school-age kids, I chose not to self-isolate. My husband works at North Kansas City Hospital, and although he does not typically come into contact with COVID-positive patients, the risk is still there. I chose instead to change into scrubs at work, remove my traveling clothes upon arrival home and take the nightly post-COVID shower. We have adequate PPE and I am confident with my donning and doffing procedures.

I am grateful for my hospital leadership. I want to recognize Dr. Michelle Haines and our administration for creating a successful structure, with daily re-evaluations of strategy, for keeping us productive and safe.

COVID-19 is an awe-inspiring force to be reckoned with. It was pretty eye-opening to see how sick these patients get and how strong this virus is. 🙄

Daily Media Briefings on COVID-19



Since the week of March 23, The University of Kansas Health System has been holding daily media briefings over Zoom and conference call on COVID-19 led by Steve Stites, MD, chief medical officer, and featuring Dana Hawkinson, MD, medical director of infection prevention and control. Besides giving a daily update on COVID patients at the hospital, the briefings also provide topical discussions with a wide variety of guests ranging from public health directors to emergency physicians to U.S. Sen. Pat Roberts. *(Pictured from left, Dr. Hawkinson, Dr. Stites and Dave Lisbon, MD, emergency physician.)*



Regulations and Payment Rules on Telehealth Ease During COVID-19

PROVIDES OPPORTUNITY TO BUILD ON EXISTING TECHNOLOGIES

By Lori Beam, JD

In normal times, telehealth systems offer tremendous benefits to both health care professionals and patients. And now what we are learning from increased use of telehealth services during the COVID-19 crisis is creating opportunities to build on our existing technologies to improve the U.S. health care system.

Telehealth systems are ideal for outbreak responses because they help triage low-acuity patients, mitigate overcrowding of hospitals and clinics, prevent unnecessary human exposure, and deliver timely quality care. Telehealth systems also help meet our everyday health care needs by enabling effective delivery of health care services to patients of all ages in all geographic locations, right when and where they are needed.

As described in the most recent issue of *Kansas City Medicine*, health care providers in Missouri and Kansas currently offer a broad range of services through telemedicine, such as primary/specialty care, psychiatry/psychology services and chronic care management. Patient populations served include seniors, millennials, school districts and urban and rural residents.

Health care providers planning to use telehealth platforms to deliver clinical services in Missouri, Kansas and other states face a myriad of federal and state legal and regulatory challenges. These include rules concerning state licensure, in-person exams, Medicare and Medicaid reimbursement, state prohibitions against the corporate practice of medicine, privacy and security of health and financial data,

medical records documentation, and fraud and abuse.

FEDERAL

In response to calls for broadening access to telehealth services during the COVID-19 outbreak, several federal agencies began taking action in the early stages of the pandemic:

- **Payment Policies**—The Centers for Medicare & Medicaid Services (CMS) and Health and Human Services Office of Civil Rights (OCR) exercised the waiver authority granted under the Coronavirus Preparedness and Response Supplemental Appropriations Act to expand payment policies for telemedicine services and relax certain federal privacy regulations. CMS's Medicare Telemedicine Health Care Provider Fact Sheet¹ explains the new payment policies effective for the duration of the COVID-19 emergency.
- **Privacy Rule**—OCR issued its COVID-19 and HIPAA emergency response notice² and related tools explaining how HIPAA's privacy rule would apply in certain telehealth situations.
- **Controlled Substances**—The U.S. Drug Enforcement Agency exercised its emergency authority to relax the normal in-person medical evaluation condition to prescription authority.

Based on these waivers and guidance, during the COVID-19 emergency:

Medicare

- Will pay for telehealth services furnished to beneficiaries in all areas of the country in all settings at the same rate as regular, in-person visits.
- Will not require the existence of a prior patient-physician relationship for claims submitted during the emergency.
- Physicians may inform patients of the availability of telehealth options, but patients must initiate the services.

OCR

- Will exercise enforcement discretion and not impose penalties for noncompliance with HIPAA during the good faith provision of telehealth services. However, states still have the authority to enforce their own health privacy and security laws.
- Lists several popular apps and products that can be used and encourages providers to notify patients of potential privacy risks of using the apps.
- Requires that public-facing communication vehicles such as Facebook Live, Twitch and TikTok should never be used to provide telehealth.

DEA

- Registered practitioners may issue prescriptions for controlled substances for patients without requiring an in-person medical evaluation if they 1) issue the prescription for a legitimate medical purpose in the usual course of their practice, 2) conduct the

telemedicine communication using an audio-visual, real-time, two-way interactive communication system, and 3) act in accordance with applicable federal and state law. However, state laws on prescription authority still apply unless the state specifically acted to waive its corresponding requirements.

STATE

Many state governors and legislatures have considered—and some have followed up on—these federal actions to relax their own requirements impacting telehealth.

Through Executive Order 20-08³, Kansas made the following temporary changes:

- Encourages physician use of telemedicine to reduce patient travel.
- Allows out-of-state physicians to use telemedicine when treating patients in Kansas without physician licensure in Kansas if they (1) give written notice to the Kansas Board of Healing Arts and (2) hold an unrestricted physician license in their state of practice and (3) are not subject to investigation or disciplinary proceeding.
- Authorizes the Kansas Board of Healing Arts to extend the same loosening of licensing requirements to other health care professionals it regulates.
- Waives the requirement that physicians conduct an in-person exam before issuing a prescription or ordering administration of medication including controlled substances.

Missouri proposed, but did not adopt HB 2566. The bill would have:

- Allowed health care providers not licensed in Missouri to provide telehealth services to patients in Missouri if they:
- + Hold an active, unrestricted license for a health care profession in

another state, territory or D.C.

- + Have never held a license subject to discipline by a licensing agency (excluding any related to nonpayment of fees related to the license).
- + Have never had a controlled substance license or permit suspended or revoked by a state or the DEA.
- + Comply with existing professional liability insurance requirements.
- Exception: Health plans are not required to reimburse health providers for telehealth services if the provider is not licensed in Missouri.

HEALTH PLANS

Several health plans—including Aetna, Cigna and Blue Cross and Blue Shield—announced they are making telehealth more widely available or are offering free telehealth services for some period of time. Vice President Mike Pence also announced a commitment from health plans to cover telehealth services, though no details were provided.

RESOURCES

Various medical associations are offering key resources for helping providers adopt and furnish telehealth services during the COVID-19 crisis:

- The American Medical Association launched the *Telemedicine Implementation Playbook*⁴ aimed at helping clinicians figure out best practices covering everything from policy and coding to implementation.
- The American Psychiatry Association issued guidance on telepsychiatry and COVID-19⁵ that includes best practices and a toolkit.

These collaborative efforts during a crisis demonstrate our overall capacity to improve quality and access to care. This

includes the work of public health officials, legislators, insurance companies, medical associations, telehealth companies, physicians and other providers, technology innovators and policy think tanks.

Once the COVID-19 emergency passes, we should continue to:

- Evaluate how telehealth services were implemented during the emergency.
- Encourage legislative action to remove hurdles while ensuring quality and ethical delivery of care.
- Make recommendations for expanded telehealth services.

Through collaborative efforts of government officials at the state and federal levels along with advocates in the health care community, we can look forward to improving and expanding the delivery of telehealth services during both emergency and nonemergency times. That will ensure a healthier future for all of us. ☺

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** This article is general in nature and does not constitute legal advice. Readers with legal questions should consult with an attorney prior to making any legal decisions.*

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Medical Student Perspectives

STUDENTS FIND WAYS TO CONTRIBUTE DURING SHUTDOWN

Medical education came to an abrupt halt in mid-March at Kansas City's three schools of medicine and across the nation. Two students, Tejal Desai and Alessandra Tozzi, who are members of the KCMS Leadership Council, share their thoughts and experience here.

Tejal Desai
Class of 2021

University of Missouri-Kansas City



Closing school has impacted us as students and our ability to get hands-on experience due to the lack of

direct patient contact. However, we have been continuing to learn and expand our knowledge in the online setting. The medical schools have done an amazing job in transitioning online so as to not interrupt our education while continuing to fulfill the core learning objectives.

Students have had a great desire to help with the COVID-19 pandemic. Although we have not been allowed back into the clinical setting, students have found ways to help out even from home. We set up blood drives through the Community Blood Center to help relieve the shortage of blood products in Kansas City. We helped with PPE acquisition, and more recently, have assisted in local testing efforts by the Kansas City Health Department. Although students have not been allowed to have direct patient interaction, we are still contributing and eager to find ways to help the health care system!

I personally have been involved with

the KC PPE drive which was started by a group of residents, medical students and friends from the KC community who had a desire to support and protect our frontline medical personnel. Several students have been involved in facilitating donations of PPE from small and large businesses in the area to local hospitals. It has been amazing to see the level of involvement from students and the desire to provide support in whatever way we can.

This pandemic has brought to light the expanding role that technology and telemedicine will play in the future. It has been inspiring to see how our medical community has come together in this crisis by sharing resources and expanding medical care in the online setting.

Alessandra Tozzi
Class of 2023

Kansas City University of Medicine and Biosciences
President, KCU Student Chapter, Missouri Association of Osteopathic Physicians & Surgeons



Being from North Carolina, I was nervous about school closing and being so far away from home.

However, KCU has been so supportive of all their students' needs during this time. We receive constant communication from our president, dean, advisers and professors about our classes as well as emails checking in on our well-being and needs. Although it was a difficult adjustment at first, I found that I was able to adapt to our

new schedule in quarantine.

Most of my days were filled with studying, since I still had three months of my spring semester left. Implementing the things I love to do (working out, reading, talking with my family and friends, and cooking, to name a few) helped break up the days and reminded me of the importance of rest. My classmates and I have found several ways to give back—from donating masks and gloves, as well as doing our part to stay home and social distance.

My class has been hosting Zoom get-togethers every week. Some of my classmates have been doing cooking demos, painting classes and showcasing other hobbies. It has been a great way for our class to come together despite being apart during this time! We have all done a good job of staying connected through our class message group, too. Some of the clubs on campus, the campus counselors and our PysD program have been hosting different programs available to all students and faculty. Included are meditations plus video conferencing and phone calls with other students

This crisis has reinforced the role my family, friends and community play in my life. I have learned to importance of finding balance between my work and my personal life and how this balance can keep me grounded, even during the most daunting of times. I am proud to be an osteopathic medical student during COVID-19. I'm proud to be on the path to become a physician—someone who can one day work at the front lines to help my community. ☺



Resident Perspective

STANDING READY FOR A POTENTIAL SURGE

By Joanne Loethen, MD

We've been fortunate in Kansas City not to have the number of cases faced in hot spots like New York. At the same time, we've been building our preparedness each day. I work with both adults and kids as an internal medicine and pediatrics resident. Overall, our hospital censuses were lower in the beginning—likely because individuals were cautiously avoiding health care settings. In return, this unfortunately meant that those who needed care were waiting to come in until they were even sicker. So, even though the number of admissions was lower, we saw patients who were more sick and in later stages of their illnesses.

In our programs, we've been preparing backup systems of residents in case a surge in cases requires more physician coverage. Fortunately, we haven't had to use it, but it's something we're continuing to keep in mind moving forward. We have a long way to go before this is behind us. Colleagues in places like New York and Boston have been pulled from their primary specialty to work in the ICUs and COVID-designated units. This is a potential event we're constantly considering, though hopeful we won't need to act upon.

COVID-19 has revealed both the best and not so great aspects of our health care system. It's fostered a united effort among

health care professionals and a unification of all working for the greater good. On the other hand, it's highlighted underlying problems of access, health disparities, moral injury and some of the organizational dysfunctions of our system. I'm hopeful (and believe) that great lessons and innovations will come from this time. Sadly, it's having to come at the expense of the morbidity and mortality of those affected by COVID-19. ☹️

Joanne Loethen, MD, is a fourth-year resident at the University of Missouri-Kansas City in the Internal Medicine and Pediatrics program. She is a member of the KCMS Leadership Council and is chair of the Missouri State Medical Association's new Women Physicians Section.

In Memoriam

Ali Arbab, MD, FACS, surgical oncologist, passed away on April 7 at the age of 90. Dr. Arbab received the KCMS Lifetime Achievement Award in 2016.

Mark Bernhardt, MD, orthopedic surgeon, died April 30 at the age of 62. Dr. Bernhardt was the Rex L. Diveley, MD, Professor and Chair of the Departments of Orthopaedic Surgery at the University of Missouri-Kansas City and Truman Medical Centers.

R. Don Blim, MD, pediatrician, died on May 11 at the age of 92. He served as national president of the American Academy of Pediatrics in 1980-81 and was chief medical officer of Saint Luke's Hospital for 10 years.

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Now More Than Ever ... Uninsured Patients Need Your Help

**Join the KCMS Foundation
in our mission to provide care
to the uninsured.**

The COVID-19 pandemic has placed its greatest hardship on the poor and working poor, especially minorities. But these individuals still have health needs. So when issues arise requiring specialty medical care, they often forego or delay care due to lack of insurance or resources.

The Kansas City Medical Society and the Kansas City Medical Society Foundation have made a commitment to help these patients through the Wy Jo Care and Metro Care programs. We need specialty physicians to step forward to donate care for the uninsured.

During challenging times like these, Americans and Kansas Citians are best known for coming together to help and support each other. Will you consider donating care to a needy patient through Wy Jo Care or Metro Care?

METRO CARE + WYJO CARE
VOLUNTEER DOCTORS FROM KCMS

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