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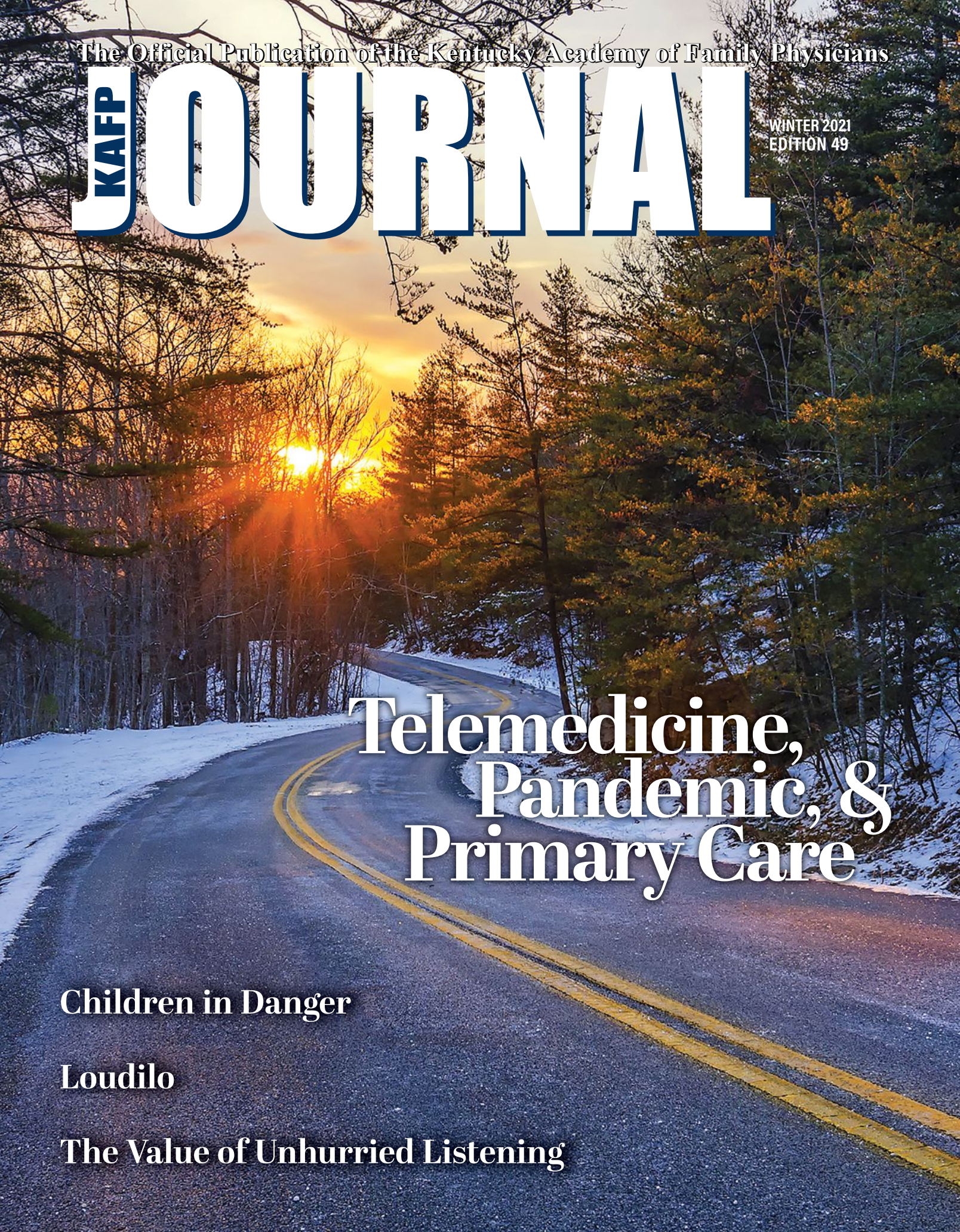

Telemedicine, Pandemic, & Primary Care

Children in Danger

Loudilo

The Value of Unhurried Listening

UNIVERSITY OF PIKEVILLE
KENTUCKY COLLEGE OF OSTEOPATHIC MEDICINE

Assistant/Associate Professor of Osteopathic Principles and Practices and Family Medicine

The University of Pikeville, Kentucky College of Osteopathic Medicine (KYCOM) is currently seeking qualified candidates for the position of Assistant/Associate Professor of Osteopathic Principles and Practices and Family Medicine. This full-time position is under the supervision of the Chair of the Department of Osteopathic Principles and Practices and the Chair of the Department of Family Medicine. This position is shared and has a faculty appointment in both the Departments of Osteopathic Principles and Practices and Family Medicine with direct responsibility for teaching, osteopathic clinical research and service in the Kentucky College of Osteopathic Medicine (KYCOM).

Duties and Responsibilities:

1. Responsible for teaching in those courses and associated labs within the Department of Osteopathic Principles and Practices and the Department of Family Medicine, as assigned by the respective chairs.
2. Participates in and recommends curriculum development and evaluation.
3. Assists in the preparation of course syllabi, objectives, lecture schedules and testing procedures.
4. Assists in the preparation of materials and documentation required for continued accreditation of the school by the American Osteopathic Association - COCA and other accrediting agencies.
5. Actively serves on appointed KYCOM Faculty and UPIKE Committees.
6. Provides clinical services as directed by the Department Chairs and Dean, which would be associated with family medicine and/or osteopathic manipulative medicine.
7. Provides counseling, advising and guidance to students.
8. Responsible for other duties as directed by the Dean.

Education/Experience:

- Must have earned a D.O. degree from an American Osteopathic Association COCA-accredited college/school of osteopathic medicine.
- Must be eligible for and maintain an unrestricted Kentucky medical/osteopathic license and obtain that license within 180 days of initial employment.
- Must be board certified by AOBFP and/or AOBNMM (or equivalent).
- Current and unrestricted DEA certificate.
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- Previous research and academic/clinical experience are desirable.

Skills/Abilities:

- Must have excellent verbal and written communication skills.
- Strong critical thinking, anticipatory problem solving and attention to detail is required.
- Ability to plan, prioritize, and organize work to complete assignments accurately and within reasonable timeframes.
- Must have current knowledge and skills in utilizing Microsoft Office Applications, including but not limited to Outlook, PowerPoint, Word and Excel. Must be able to learn and use Learning Management Systems such as Canvas; and the university online platform and systems.
- Must demonstrate cooperation, courtesy, and consideration when working with the professional community, KYCOM and UPIKE communities, faculty, students and the public.
- Must be able to work independently and as a member of a team.

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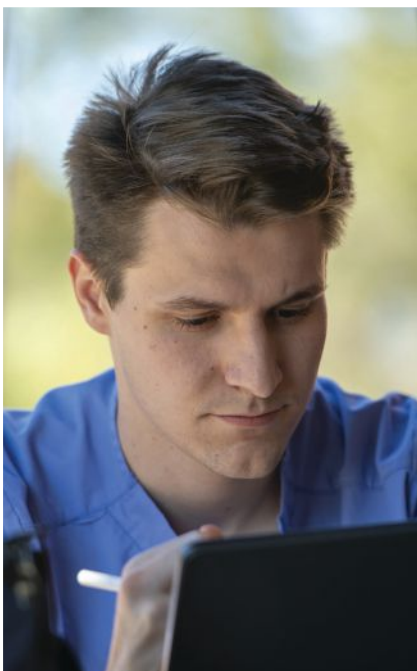

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KENTUCKY ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR KENTUCKY

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BY ASHA SHARMA MD, FAAFP, *PRESIDENT*

message from Your PRESIDENT

I hope everyone enjoyed a happy and safe holiday season and rung in the year 2021 with hope and promise of an exciting year ahead.

During this time of constant change, I was inspired to spend some time during the holiday season reflecting on my own decision to become a physician. I came across the following quote that resonated with me:

"A good doctor's comforting and reassuring words are sometimes more powerful than medicine."

- Anonymous

This quote made me think of my grandmother who passed away when I was 8 years old. When I was very young my grandmother was diagnosed with leukemia. Her primary care physician spoke with my parents and my aunt regarding her diagnosis and condition. My grandfather had passed away recently, and my parents and aunt were concerned about the devastating impact this may have on my grandmother's will to live. My grandmother lived out the next 7 years with joy and happiness, never aware of her diagnosis or potential treatment plans. Her primary care physician's respect and support for my family's wishes struck me years later – their physician-patient-family relationship was truly special and unique. The primary care physician took care of the family as a whole – treating both my grandmother's terminal illness while respecting the wishes of her family and supporting them through all parts of my grandmother's care and death.

Looking back this interaction took place at a time when cultural diversity was not part of the norm. The year 2020 has brought its challenges, and along with it has highlighted the special place that Family Medicine has in taking care of our patients. We have had to meet our patients and our colleagues where they are in respect to home care, hospital care, urgent care, office care, and video/telehealth care. We have had to be "outside of the norm", comforting and reassuring in new ways. In many cases, we have not had medication to cure or to heal – we find that our words and our actions are much more powerful.

With all the change that 2020 has brought upon us, I invite you to take some time to reflect on what inspired you to become a physician and what experiences led you to choose the path of a Family Medicine Physician. Many of us can think of examples like my experience with my grandmother's primary care physician that opened our eyes to the wonders of Primary Care and the ability to make a difference.

This drive and hope of making a difference is strong in medical students and residents. Their passion and excitement are contagious and often renews our own faith, reinvigorating us in our practices. They too have had to adapt to alternate forms of education, clinical experience, and finding their own ways to make a difference during this challenging time. The KAFP has an opportunity to step up and motivate students and residents to keep their passion for medicine strong – highlighting the primary care role demonstrating adaptability, strength, and compassion. Engaging and involving medical students, residents, and those early in practice is vital to building on our strong foundation of the KAFP.

In November I had the opportunity to meet via Zoom with University of Louisville medical students involved in the Family Medicine Interest Group. We discussed what led me to primary care and the many roles played in clinical practice today. We discussed application processes along with different avenues one could choose to take in their practice. Their curiosity and excitement were inspiring. The conversation revealed their dedication to achieving their goals despite all the academic changes that they have faced. In a time such as this we depend on students such as these to continue to build a strong medical profession. Being available to them to have these types of discussions is what highlights our role modeling to these young physicians. Even a short interaction may lead to a lifetime of impact on a student or young physician. My hope is that more of these opportunities will take place, and I ask each of you to reach out or be available for students to mentor them, to help them navigate such a challenging time. I am looking forward to an upcoming event with University of Kentucky's Family Medicine Interest Group in January.

You may wonder how you can get involved on a personal level with students and residents. I am hoping to create a simple directory of KAFP members that includes medical residency location, practice type and location, and brief areas of interest. This would help engage our students/residents and develop personal relationships with them. This would not be a published document, but rather a way that KAFP staff and leadership could help link up students and KAFP physicians to facilitate interaction. This is not meant to add time or burden to our already busy lives, but a way to propagate interest in Family Medicine and recruit fresh faces to the KAFP.

Within our current KAFP membership I hope that some of you are considering joining a committee or finding a small way to get involved. Participation in the KAFP is a form of connection that many of us are missing with the current challenges we face. Engaging with fellow physicians, invoking change, stimulating ideas, and supporting each other is rewarding and inspires each of us to get out of our norm – to push Family Medicine to the forefront. In numbers and solidarity there is strength that inspires others.

Within our current KAFP membership I hope that some of you are considering joining a committee or finding a small way to get involved. Participation in the KAFP is a form of connection that many of us are missing with the current challenges we face.

Over the next few months, I am hoping for opportunities to meet with other chapters within the AAFP to add other pathways for student/resident interaction and promotion of our own chapter. I would love to hear from KAFP membership regarding what topics you would like to hear about, what I can be helpful with, or questions you may have. The KAFP leadership has our winter Board Meeting in January and we are in the planning stages of a mini-meeting in the spring season and the annual meeting for the late summer.

Please contact me at asha.sharma@thechristhospital.com to discuss any issues or ideas.

I also encourage our members to visit our website at www.kafp.org to stay up to date on news and upcoming events.

Respectfully,
Asha Sharma, MD, FAAFP

By A. Stevens Wrightson, MD

Letter From the Editor

Worry. I suppose that is the overwhelming emotion we are all experiencing because of COVID-19. There is plenty of worry to go around. Worry about ourselves as health care providers, our families, our patients and the state of the country and the world. This week, one of my siblings and another close co-worker have been diagnosed with COVID-19, so the circle of protection I think I am creating for myself is getting smaller and smaller. Some of you have already experienced infection firsthand and probably have experienced catastrophic illness, if not in yourself, in a loved one or a patient. When can the worry be put behind us?

I was recently reminded that the opposite of "faith" is not disbelief...it's worry.

Although the pandemic is a tragedy, there are some positive things I can reflect on to combat the worry that attempts to overcome faith, the faith that this crisis will eventually end.

1. Relationships, especially with those in our bubbles, have become much stronger for some of us. I need to say that I have 4 adult children ranging in age from 22 to 30. Two of them are still in graduate school, and only one has recently moved out into an apartment near us. My daughter in school in Philadelphia does all her graduate work by zoom and email, so she is home as well. We have family meals most nights, sometimes twice a day. Yes, we will sit together in a room and all be on our phones, but there is ample time to talk about dreams, frustrations, the future, and appropriate COVID-19 protections. This is 9 months of togetherness that would never have happened otherwise. I do not think our family is the only one experiencing this. In my neighborhood and around town, I see families on bike rides together, or sitting on porches together, or even at the grocery together (usually with all sizes of masks). Seeing these families interact makes me feel our communities have a chance to get to the other side of this pandemic.

2. Less traffic and less CO2 emissions create some unexpected environmental benefits. We drive when we need to, which is not too often given that my wife and I can work at home several days a week. This is a pattern that is seen across the country, more pronounced, early in the pandemic, and probably increased again in the Winter surge. It really brings into focus how intentional we could be about using our cars and our precious resources.

3. I think we all now get it, this thing about handwashing. We are also getting pretty good about mask wearing and social distancing. Overall, our attention to hygiene is creating a change in how we live that will likely improve our health even after COVID-19 fades away. This year, according to the CDC, influenza activity is low to minimal across the country.[1] I cannot but think that the handwashing, mask wearing, and social distancing practices are helping keep the flu at bay.

4. At work, rather than sit right next to each other, our staff must spread out. In some cases, the medical provider is not even on site, but rather doing telehealth from home. This has created new opportunities to develop innovative ways to communicate and streamline activities such as check-in, patient education, follow up, referrals, and laboratory testing. Our Behavioral Health staff spent the first 6 months of the pandemic at home, doing 100% of their sessions via telehealth. We were still committed to providing integrated behavioral health services, which included same-day, warm hand offs (WHOs) when needed. So, we developed our TeleWHOs whereby the patient was seen at our clinic, an iPad was wheeled in, and the patient was connected with a Behavioral Health Provider at home who performed their encounter. The technology was the same as what we use for a hearing-impaired patient and it worked very well for both Behavioral Health WHOs and Clinical Pharmacy WHOs. Ultimately, the National Association of Community Health Centers included this process in a toolkit of innovations developed to address COVID-19 related barriers.

5. For many of our patients and some of our staff, working at home has become mainstream. The flexibility of telehealth appointments means more opportunity to stay on time, and a lower no-show rate, especially with behavioral health visits.

6. 2020 has become the year of social responsibility. I know there is still an independent streak out there, but I am confident that most people understand that we really "are in this together" and therefore, we need to do our part. When I need to go to the grocery, or Lowe's, or wherever, businesses cooperate with the public health measures we as physicians know to be effective. I know that this is marketing and survival to some extent, but I feel it is, in a sense, a demonstration of corporate responsibility as well. My son works at a coffee shop chain and they are very protective of their staff, and the staff in turn take care of each other and their customers. Ultimately, caring for others provides value in our lives. That is why we were drawn to Family Medicine.

7. Finally, as this pandemic drags on, many of us must experience a sense of gratitude. "Gratitude!" you say, "Are you crazy?!" Many of us are still working, still housed, and still healthy. There is a lot for people to be worried about, even angry about, but it does not seem right that I should be worried or angry, at least not yet. I am thankful I can say that.

My wife says I have rose-colored glasses. I suppose I do. The COVID-19 pandemic is the worse health crisis we will ever see, I am sure of that. I pray for those who have died and for the families who have lost loved ones: that you will have peace. For every positive I have mentioned there are scores of negatives. I just wanted to share a bit of faith, which is probably more productive than too much worry anyway. I will include a couple articles that share these ideas.[2, 3, 4] Be safe, wear your mask, wash your hands, hug those in your bubble, and call those who are not in your bubble all the time!

Endnotes

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BY BOB BABBAGE, BABBAGE COFOUNDER

LETTER FROM THE LOBBYIST

In the ever-evolving story of the novel coronavirus, certainty is hard to come by.

However, experts across the world are in strong agreement as data reinforces a distressing collision of multiple pandemics: COVID-19 and chronic health conditions. As state leaders review the impact of COVID-19 and how prepared Kentucky is to deal with the crisis, the links between specific health issues and the virus are crucial to understand and address.

The effects of the interaction of COVID-19 and chronic health conditions are staggering. A study of 16,780 hospitalized COVID-19 patients found that 77% were overweight or obese, 56% had hypertension, and 20% had diabetes.[1] Of the 110,000 Medicare beneficiaries hospitalized with COVID-19 from February to May, 50% had diabetes.[2]

Public health experts at UNC Chapel Hill have found that those with a body mass index of over 30 have a 113% greater risk of ending up in the hospital with COVID-19, a 74% increased risk of needing intensive care, and 48% increased risk of dying from the virus.[3]

In light of Kentucky's troubling health statistics, the long-term impact of the virus on individuals with chronic conditions could be significant.

Sara Jo Best, the President of the Kentucky Health Department Association, said it this way: "Public health officials in Kentucky have been concerned about the health status of our residents for quite some time. Kentucky's population has increased rates of asthma, cancer, heart disease, diabetes, obesity, and hypertension. All of these put our people at compounded risk for negative outcomes if they become infected with COVID-19."

How is Kentucky impacted?

In Kentucky, 36.5% of Kentucky adults are obese and 23.8% of children age 10-17 are obese.[4,5] These statistics place Kentucky number five in the country for adults and number one for childhood obesity in that age bracket.

The state's population affected with hypertension and diabetes also ranks in the top ten. Kentucky's diabetes rate is the fifth highest in the U.S., and diabetes ranked seventh among the state's leading causes of death in 2017.[6]

Over the past 30 years, the rate of obesity has increased by 200%.[7] In the past 20 years, diagnoses of diabetes have doubled.

Additionally, the financial impact of chronic health conditions on our bottom line is alarming. Obesity accounts for 21% of national healthcare spending, which is roughly $210 billion a year.[8] One in every seven healthcare dollars is spent treating diabetes and its related complications.

In 2017, the total cost of diabetes for Kentucky Medicaid beneficiaries was $116,998,573.[9] That averages out to $1,156 per beneficiary. The medical cost for Medicare beneficiaries who have obesity was $2,018 higher per year than those of normal weight.

With rates of chronic disease continuing to increase, the devastating health consequences and financial burden will only grow. That is, unless we take action.

What do we do about it?

Per Best, "Improvements to our health status continue to be something that public health professionals across the Commonwealth agree need additional progress."

The same alignment is true among legislators, regardless of political party, according to Rep. Kimberly Moser, Chair of the House Health & Family Services Committee, "We all have the same goals; we sometimes just have a different way of achieving those goals. A lot of that is experience. Once you work in this world for a while - not just the legislative world but also health - you understand that it's not as black and white as [it may seem]."

A good place to begin is reducing barriers to effective treatment. One such example is access to obesity treatment, a comorbidity that is closely correlated with a long list of health conditions. The Treat and Reduce Obesity Act of 2019 (HR 1530/S. 595), sponsored by Congressman Brett Guthrie (KY-02), aims to combat obesity in older Americans by eliminating major barriers to obesity treatment and prevention. If passed, TROA will expand Medicare beneficiaries' access to additional healthcare providers and will extend Medicare Part D coverage to FDA-approved obesity drugs.

Access to treatment is critical, but prevention and education are key to bringing down rates over time. Additionally, Moser points to awareness "as a big part of what we're doing that we may not always think about - nutrition, exercise, preventative well checks, having access to care, ensuring that our Medicaid system remains that safety net for those whom it was originally intended."

In recent years, the state has taken steps to address these challenges to Kentuckians, even before the pandemic was a complicating factor. Chair Moser and Best both cite the Smoke-free Schools legislation, HB11 (Moser), passed in 2019. This measure received support from a broad coalition that included the nonprofit Foundation for Healthy Kentucky, an influential policy organization led by President and CEO Ben Chandler. Such coalitions of community and policy leaders are critical in solving issues related to chronic health as there is no single solution.

The news around COVID-19 is consistently grim, as are the chronic disease statistics Kentucky faces. There are major implications impacting a productive workforce, state resources, and most importantly - quality of life. A silver lining to offer is this: the pandemic is increasing a sense of urgency for action. The "slow" nature of these chronic condition epidemics, relatively speaking, have allowed for a degree of complacency to exist. COVID-19 is changing that, as the global health crisis brings desperately needed attention to these issues.

Given all this, can Kentucky lead a discussion about a new era of focus on chronic illness, its complications and impact? Legislative leaders have consistently said that the 2021 session will revolve around addressing issues related to COVID-19. It is imperative that the conversation include tackling long-standing health challenges complicated by the pandemic, chronic diseases being chief among them. You, as family physicians, can help guide these efforts towards greater wellness. We will continue to examine strategies and action needed for better outcomes for your careful review.

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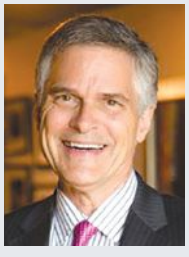

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By Claudiu Moisa, MD; Ashley Iles, MD

Children in Danger

Throughout this pandemic, primary care providers have been called upon to address deteriorating health issues on numerous fronts: direct patient care, advocacy for public health policy, vaccination education to name a few. The long, growing list is burdensome and can be overwhelming. While it is not our goal to add burden to our already strained practices, child abuse in light of this pandemic is an issue that must be acknowledged and addressed especially in our Commonwealth of Kentucky.

The federal government defines child abuse (and neglect) as "Any recent act, or failure to act, on the part of a parent or caregiver that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm."[1] This broad definition includes categories of provisional neglect, physical abuse, sexual abuse, trafficking, and psychological maltreatment. Often, victims endure more than one of these categories.[1]

The scope of the problem

National data available through 2018 places Kentucky at the top for highest rate of abuse at 23 per 1000 children, compared to 17 per 1000 children in 2014.[1] The national average for 2018 was 9.2 per 1000 children.[1] Data available from the Kentucky Cabinet for Health and Family Services (CHFS) reported a total of 308 deaths or near-deaths of children from maltreatment or neglect between the years 2015 and 2019.[2] The situation is not better across the river in Indiana, which is the second highest state in terms of death rate with 80 children who died in 2018, much worse than their 34 fatalities recorded in 2015.[1]

Although data accuracy is arguably limited given the numerous, complicating factors involved in reporting, any number greater than zero is unacceptable in reference to child abuse incidents. Tragically the most vulnerable are the most at-risk for fatality caused by abuse. In Kentucky from 2015-2019 children age four or younger represented 85% of the maltreatment deaths and near deaths, with 40% under one year of age.[2]

Why would the pandemic make it worse?

There are some early indications and historical patterns that support the position that the COVID-19 pandemic has exacerbated this urgent issue.[3-5] More literature is being published weekly on

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this topic, including policy recommendations and intervention recommendations from the American Academy of Pediatrics (AAP).[6,7] There is no question among experts that children are in danger. Children are spending more time at home with potential abusers, and their adult caretakers are enduring extra stressors of various kinds which increases risk of abuse.[8,9] Furthermore, because of public health measures to curb viral spread, children have less contact with adults outside the home. This fact may explain an early trend in decreased abuse reporting in Kentucky, but also inhibits early intervention for these children if abuses are not being identified by educators, day care workers, community members, etc.[10]

Why is it a primary care issue?

As primary care providers, we may be some of the only professionals that these children still see semi-regularly, whether they are coming in for routine visits or abuse related injuries. And as family medicine practitioners, we are uniquely positioned to address stressors and mental health decline in our adult patients as well. The comprehensive solutions to this widespread issue are far beyond the reach of our practices.[11,12] However, with children at-risk and suffering injustices in our communities, we must do our part in practice to assist and protect the vulnerable.

What can we do about it?

Child abuse and child fatalities caused by abuse are preventable. Child abuse events are often repetitive in nature and increase in severity over time. By intervening early, we can save a life. Key points of practice for primary care providers include re-educating ourselves on signs of abuse, educating parents and caregivers, routinely screening patients for risk factors, and knowing the reporting rules and resources in our communities. Let's use a few examples to demonstrate what this may look like in your office.

A two-year-old girl comes in with her mother who has three other children at home who are partially cared for during the day by a few extended family members and non-relatives who stay with the family. You notice that the little girl has a flattened growth curve by weight since a sick-visit 2 months ago. As an astute provider, you would note the risk factors for abuse in her situation including single-parent home, young patient age, and non-relatives living in the home.[12] Interventions would include parental education regarding appropriate discipline techniques for the patient's age and discussing mitigation of abuse risks given the make-up of her residence.[12] Additionally, a thorough review of the patient's nutritional history and habits, food insecurity questions, referrals to community food resources, and close follow up are all warranted.

At another visit, you are seeing a 13-year-old boy who needs an updated sports physical to clear him for football. Looking through his history, you notice he has already had a concussion and multiple ED visits for broken bones over the years, including a rib fracture. During the visit you noticed his behavior is reserved and affect flat. On physical exam, you also notice bruising on his left ear and neck that his accompanying parent said was from "practicing football at home" in pre-season preparation. Being aware of signs of abuse, you already know that suspicious bruising and unusual fracture patterns require further investigation. At this point a more thorough history and physical would be warranted, and the AAP in their latest collection, *Child Abuse: Overview and Evaluation,* is an excellent resource for guidance about how to conduct interviews in this scenario with both the parent and the patient.[12]

There are an endless number of ways in which child abuse may present to primary care, and the above two examples are not meant to be comprehensive, merely illustrative. If we are not familiar with the most common signs of neglect, verbal abuse, sexual abuse, and physical abuse, we need to educate ourselves further. Many common patterns of injury associated with physical abuse are detailed in the literature as sentinel signs with which we should be familiar.[13-15] Unfortunately, there is not a single screening modality that will identify all potential victims for us.[16] Rather, we need to be aware of when behavior patterns, injuries, complaints, or exam findings do not match the history or story we are being told and follow up appropriately with further investigation.

After completing an evaluation of a patient, thorough documentation of all findings is important, and you will need to know when and how to report your concerns. In the Commonwealth of Kentucky, "any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately cause an oral or written report to be made" (KRS 620.030(1)). Therefore, even non-physician community members are required to report concerns, and if you have reasonable suspicions regarding a child that is not your patient, those also need to be reported. This can be done by calling the appropriate hotline (The Kentucky Child Protection Hot Line at 1-877-597-2331) or submitting an online report for non-emergency cases only (https://prd.webapps.chfs.ky.gov/reportabuse/home.aspx).

Conclusion

Ultimately, preventing child abuse requires involvement from entire communities. But we must recognize the lack of community and social interaction we all are experiencing is putting our most vulnerable citizens at risk. Therefore, increased provider and public awareness is critical, and we should take this opportunity to re-educate ourselves as medical professionals where necessary. In our offices, we should have policies in place for risk factor screening and reporting concerning findings, as well as being familiar with the family supports and resources available in our communities. In this 2020 year, many more obstacles than usual are inhibiting patient care, but our resolve to help the patient in front of us must not falter. It can make a large impact in that patient's life, or even save it.

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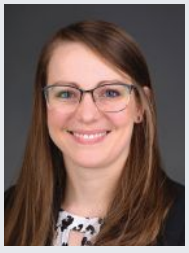

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BY ROHIT S. NAIR, MS, MBA

Loudilo

July 7, 2018 will forever go down as the first day I truly felt like a medical professional. It was the sixth of our eight clinic days on the University of Louisville School of Medicine service-learning trip to the beautiful African nation of Tanzania, in partnership with the Foxes NGO and the Mufindi Children's Orphanage. Being on this trip was how I wanted to spend the summer between my first and second years of medical school, but I had no idea about how impactful the memories shared between me and 14 classmates on the trip would be. As a group, we treated over 1000 patients living in remote villages in the mountainous Iringa district – who often only receive healthcare services when brigades set up travelling clinics in their village once a year. Over 35% of the population in this region is HIV positive.

View from the clinic building in Loudilo

Being on this trip was how I wanted to spend the summer between my first and second years of medical school, but I had no idea about how impactful the memories shared between me and 14 classmates on the trip would be.

In addition, we had the opportunity to see other conditions we rarely see back home. My fellow classmates and I all honed in on skills learned during our first year of medical school, including the physical exam and history taking. We also experienced countless firsts – our first time doing intramuscular injections, our first time debriding wounds, our first time helping out in a pharmacy, our first time taking real patient histories, and our first time presenting patients to an outstanding group of humanitarian attendings. With this background, I will share one particular encounter which ties together so many of the elements that made my first trip to Africa a life event that solidified my decision to be a physician.

On July 7th, I was on travel clinic duty in the village of Loudilo, which is an hour drive from our home base at the Mufindi Children's Orphanage. When we set up in these villages, we would create makeshift clinics in community centers which were often mudbrick structures without any electricity or running water. I spent the morning like how I had spent most of the preceding days, seeing patients in a dark room with the aid of Swahili interpreters. After lunch, it was my turn to be on wound care duty and let one of my classmates take over the patient room. However, most of the people who needed wound

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A patient room in Loudilo

care had come in the morning, so there was not much action at the wound care station. In contrast, there were numerous patients waiting outside the clinic for their turn to be seen after being checked-in. Since I was not busy, I decided I would try to be helpful. Luckily, Mr. Geoff Knight, one of the directors of the Mufindi Children's Orphanage, happened also to be close by. I did not have an interpreter assigned to me at the time, but Mr. Knight knows some Swahili - so we decided we would start taking the medical histories of the patients waiting outside in an effort to accommodate as many patients as we could.

The very first patient we talked to was a 27-year-old woman with a chief complaint of dizziness when she stood up. Even with my amateur history-taking skills, I knew to ask if she was pregnant as part of my line of questioning. This was uncomfortable because the people in this culture are very private, and without a private room available there were many other people within earshot as we took this history on a bench outside the clinic building. Due to this, Geoff translated this question in a very euphemistic way, but she denied being pregnant. I checked her blood pressure and it was normal. With limited diagnostic testing options, we decided to check a pregnancy test for her just to be sure. At this point, Geoff had to leave, so it was just me and the patient with a large language barrier between us. With mainly hand signals, I indicated to the patient she should go to the nearby outhouse and urinate in a cup. I grabbed a pregnancy test strip and waited outside the outhouse for the patient to finish while I studied the label for what would constitute a positive result. She came back with the sample, I put the test strip in following the

instructions, and sure enough two lines appeared on the strip indicating a positive test.

So there I was, standing with the patient, test results in hand, with no way of telling her this life-changing news. I signaled for the patient to wait there, since I wanted to maintain as much of her privacy as possible. I sought out Dr. Ellsburg, a pediatrician on our team, who confirmed that the test was indeed positive. At this point, I borrowed my colleague's interpreter, led him back to where the patient was and mentally prepared myself to deliver the most important news I had ever told anyone at this point in my young medical career.

When the Swahili words for "the test was positive, it looks like you are pregnant" came out of the interpreter's mouth, the patient's jaw dropped – she looked absolutely shocked and then replied to the interpreter. The interpreter turned to me and said "she cannot believe it" with an expressionless face. For a moment I thought, "Oh no, what if that is not what she wanted to hear? What do I say next?" But as I processed that thought, the patient's face lit up with excitement. She did a celebratory jump, and she had the biggest smile I have ever seen as she proceeded to hug me. I wanted to share this pure moment of human emotion with her in her language, so naturally the first thing that came to my mind to exclaim was "Hakuna matata!" It literally means "there are no troubles" or "no worries," as popularized by Disney's *The Lion King*. Turns out, she and her husband had been trying to have another child for the past two years. She thanked me for giving her "the best news [she] has ever heard." We gave her some pre-natal vitamins and sent her on her merry way, while Dr. Smock, our lead faculty advisor, explained to me how pregnancy can cause orthostatic hypotension and dizziness.

The outhouse in Loudilo

In the time since our service-learning trip to Tanzania, we have been immersed in the intense middle years of medical school. It can be tedious to study for days at a time, but any time I find myself overwhelmed, I think of how happy that one woman in Africa was when I told her she was pregnant. I feel proud that we were resourceful enough to be able to touch so many lives in those eight days. In how many other careers can you experience such an interesting situation in such a remote place in the world with such a happy ending? This was just a story about a first, and I know I will one day have to break bad news too. But I am so thankful to be in a field where I can travel anywhere in the world and provide value to fellow humans. This experience and many since have confirmed that I made the right choice regarding how I want to spend the rest of my life. And to that I say, "hakuna matata."

Rohit S. Nair is currently a 4th year medical student at the University of Louisville School of Medicine. He was selected for the Trover Rural Track, where he has been able to complete parts of his medical education in his hometown of Madisonville, Kentucky. Rohit completed his undergraduate studies in Neuroscience and Psychology at Vanderbilt University, and his M.S. in Physiology and Biophysics and M.B.A. at the University of Louisville. He is applying to Internal Medicine residencies this Fall and intends to pursue a career in Cardiology or Hematology/Oncology.

BY SMITA UPADHYAY MD MPH, REBECCA FLORA MD

Telemedicine, Pandemic, & Primary Care

Human civilization is witnessing the worst health crisis in recent times. What began as a small cluster of infections in Wuhan, China spread expeditiously. Within three months, COVID-19 (Coronavirus Disease 2019) was declared a pandemic with over a million lives lost worldwide.[1] COVID-19 has not only affected the physical health of our population but has greatly impacted psychological health as well. This should not surprise us as similar effects have occurred in previous health crises.[2] Studies early in this pandemic have demonstrated an increase in anxiety and depression, a trend being reported globally.[3,4] An increase in suicide rates may also be seen in the near future.[5]

Fear of contracting the disease, stigma, confusion, resource deficits, uncertainty, and the incessant flow of negatively skewed information has resulted in hysteria and panic.[6] Stress, anger, insomnia, mood disorders, and substance abuse have all increased in the general public and worsened in those with preexisting issues.[4] Measures to curb the pandemic have added to economic hardships and have taken a toll on emotional well-being.[7] People of all ages have been affected by this virus. Closure of playgrounds and schools have denied children the valuable experiences that are fundamental to long-term development and success. Parents have been overburdened with financial strains and multitasking since the closure of childcare facilities. Efforts to protect the elderly physically have increased their isolation and loneliness. Healthcare professionals who have stepped up to the unprecedented demand are experiencing burnout and living in the constant fear of contracting the disease.[8]

This ongoing pandemic shows no signs of abatement and underscores the need to have a robust system for primary care providers to offer support to our populations without putting them at any additional risk. Increasing access to healthcare while minimizing person-to-person interaction is critical to curbing viral transmission. This pressure has necessitated dramatic and innovative changes in healthcare delivery. One of these critical innovations has been the advancement of telemedicine (or telehealth) services.

Telemedicine has been around for some time. However, sparse utilization prior to 2020 was largely due to lack of uniform regulations. Additionally, there have been

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Increasing access to healthcare while minimizing person-to-person interaction is critical to curbing viral transmission. This pressure has necessitated dramatic and innovative changes in healthcare delivery. One of these critical innovations has been the advancement of telemedicine (or telehealth) services.

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other barriers that have limited the wide-spread use of telemedicine: lack of internet access, lack of familiarity with technology, lack of access to cameras, security breaches, regulatory barriers, and lack of being able to perform physical exams, amongst many others.[9]

Several measures have been taken to limit barriers and increase adoption of this mode of healthcare delivery where appropriate. The enactment of the Bipartisan Budget Act in January of 2020 improved the telehealth options for Medicare Advantage patients by removing restrictions on the physician and patient site for telemedicine.[10] Federal agencies have also promoted telehealth during this pandemic through regulatory relaxation and increased funding. The CMS (Centers for Medicare and Medicaid Services) extended the telemedicine benefits to all Medicare enrollees (as had been granted earlier to those enrolled in the Medicare advantage plan) through the temporary relaxation of the telemedicine rules via Waiver 1135 and the Coronavirus Preparedness and Response Supplemental Appropriations Act. Further measures have helped increase the adoption of telemedicine, such as equal reimbursement for a telemedicine visit as an in-person visit, suspended licensure and malpractice insurance restrictions, waiving HIPAA regulations for video visits, and allowing for outside state providers to care for patients.[11,12] Additional funding from the Federal government through the COVID-19 Telehealth Program and the Rural Health Care Program (which aim to make telemedicine services available to geographically remote patients) have provided necessary impetus.[13]

The concept of telemedicine, delivered either in synchronous or asynchronous formats, has existed since the advent of communication technology. In the 1950's telemedicine and tele-therapies began to rise in popularity in rural areas in the United States. Most notably, in 1959, the Nebraska Psychiatry Institute was providing group therapy, long term therapy, and consultation-liaison psychiatry via videoconferencing. Telemedicine has grown since these early years and expanded, especially towards managing mental health issues. In fact, a study from 2005-2017 among millions of privately insured enrollees found that most telemedicine visits were for mental health reasons.[14]

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Ramaswamy and colleagues recently reported Press Ganey patient satisfaction survey scores from outpatient encounters and found that patient satisfaction with video visits was significantly higher than in-person visits, both prior to COVID-19 and during the COVID-19 period.[15] Increased satisfaction lays in the cost-effectiveness, greater flexibility between service users, and the removal of certain treatment barriers such as stigma, to receive social support particularly in case of men.[16]

As primary care providers, we should strive to utilize these new technologies to optimally care for our patients, especially in the realm of mental healthcare, which has already demonstrated historical efficacy.[17] Soklaridis and colleagues discuss non-psychiatric mental health supports can be effective in addressing mental health concerns during medical pandemics.[18] Additionally, a 2008 meta-analysis of 92 studies demonstrated no statistical differences between internet-based psychotherapy and face-to-face therapy for patient outcomes.[19] As primary care providers, we have a great deal to offer these patients who are suffering.

Initiating such efforts can be a tremendous undertaking, especially for offices unfamiliar with these new practice approaches. One helpful guide for primary care providers on implementing telehealth is AAFP's "Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice".[20,21] This toolkit provides suggestions on maximizing telehealth in regards to physical exams, coding, pre-screening and the various platforms available for telehealth use. In regard to mental health in particular, they recommend making sure the patient feels safe by having open dialogue about the limitations of technology, the physical location of the patient (are they somewhere they feel safe discussing their health and mental health?), and utilizing screening questions for problem-identification (for example, PHQ-2 or PHQ-9). It may be helpful to have such screening tools sent via secure messaging to the patient prior to the actual visit.

Sometimes patients will require an escalation of care beyond what primary care can provide. In such cases our mental health professional colleagues may be able to administer psychotherapy, counseling, and supervision in different methods such as hub-and-spoke, integrated care, direct-to-consumer, and mobile applications. The adoption of these methods has supplied patients with improved access to health care professionals in a cost-effective way. [21]

Several studies have shown "that building a successful therapeutic relationship between therapist and client is more fundamental to the effectiveness of psychological interventions than the specific therapeutic model or approach".[16] Therefore, one possible objection to the use of telemedicine techniques in mental health care is the loss of non-verbal communication such as eye contact, facial expressions, and body language, especially if using audio-only. However, there is evidence to support that e-therapies are equivalent to face-to-face therapy in terms of therapeutic alliance by some studies.[16] It is also worth noting that during a pandemic the more appropriate comparison may be to no care at all, rather than in-person care, since in-person services may not be a viable option.

As primary care providers, we have the opportunity to be at the frontlines of this pandemic and take action in a holistic way. The numbers of those affected with COVID-19 continues to rise. As we continue to see loss of life, jobs, education, and economic stability, we will also see increases in stress, fear, anxiety, and depression in our patients. In our clinics and hospitals, we scan every patient for fever with a temperature check and perform a screening questionnaire to assess for COVID-19 exposures and symptoms. In similar fashion, why should we not screen for behavioral changes and depression symptoms in every patient as well? Why not take the time to screen everyone we see by simply asking the patient how they are holding up during this pandemic? It is our duty as primary care physicians in this climate of uncertainty to be aware of and address the psychological sequelae that might persist much longer than the pandemic itself. We should consider how to best wield the tool of telemedicine in our practices to do just that.

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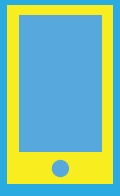

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Smiles for Life, A National Oral Health Curriculum, Launches New Website and Updated Edition of Its Innovative and Accessible Curriculum for Educators, Students and Primary Care Providers

Oct. 22, 2020––Smiles for Life, a free online educational resource designed to ensure the integration of oral health and primary care, announced today the launch of its new, easy to use, smilesforlifeoralhealth.org website and app. The site includes the recently updated edition of its widely praised curriculum and enhanced set of educational tools and resources.

"Good oral health is more than just preventing cavities," said Dr. Melinda Clark, Smiles for Life editor, pediatrician and professor at Albany Medical Center in New York. "Poor oral health impacts a variety of conditions such as preterm birth, diabetes, obesity and cancer. Because 60 million Americans lack proper access to dental care, Smiles for Life was developed to integrate oral health with primary care, literally saving lives."

The Smiles for Life curriculum, endorsed by more than 20 professional organizations, is offered free of charge to health care providers, students and educators. It consists of eight 60-minute modules covering core areas of oral health. The curriculum is also certified for continuing education credits across multiple professions including physicians, nurses, PA's, medical assistants, pharmacists, and dental health professionals. Users measure their progress through assessments at course completion. Those who score 80% or higher receive credit for each course.

Clark added, "Smiles for Life offers off-the-shelf resources, making it easy to incorporate oral health directly into your practice or classroom curriculum."

Tools include patient handouts and posters in multiple languages, patient care training videos, guidelines and statements, publications, clinical cases, and more. All content is downloadable, so educators can easily incorporate the content into action. The curriculum can also be used to satisfy interprofessional educational standards, and includes an app that can be used as a reference tool designed to assist primary care providers in formulating a diagnosis in real-time. Clinicians select an algorithm based on the presenting concern of the patient or physical exam finding, and the decision tool presents a series of questions to help formulate a diagnosis, triage and treatment plan.

> *"Smiles for Life offers off-the-shelf resources, making it easy to incorporate oral health directly into your practice or classroom curriculum."*
>
> *– Dr. Melinda Clark*

About Smiles for Life

Smiles for Life produces educational resources to ensure the integration of oral health and primary care. Smiles for Life, a national oral health curriculum, was originally developed in 2005 by the Society of Teachers of Family Medicine Group on Oral Health. Smiles for Life is now the nation's most comprehensive and widely used oral health curriculum for primary care clinicians. It has been officially endorsed by more than 20 national organizations, and is in wide use in professional schools and post-graduate training programs. There is no cost to participate in the program, and Smiles for Life is certified for continuing education requirements.

Smiles for Life is funded by the National Interprofessional Initiative on Oral Health (NIIOH), whose activities are made possible by a collaborative network of funders sharing a common commitment to enhancing the role of primary care clinicians in the promotion of oral health. To learn more please visit smilesforlifeoralhealth.org.

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BY BRANDON DODD

The real social history:
The Value of Unhurried Listening

INTRODUCTION BY WILLIAM J. CRUMP, M.D. ASSOCIATE DEAN, UNIVERSITY OF LOUISVILLE SOM TROVER CAMPUS

Introduction

In June of each year for almost 24 years, the University of Louisville Trover Campus has hosted a group of prematriculation students who spend three weeks in the host town of Madisonville, population 20,000, prior to beginning medical school.[1] The goal is to immerse these students in a rural experience with a focus on patient-physician communication.[2] Recently, this has included only those students who would later return for their clinical M-3 and M-4 years at this rural campus. In the 2020 session, we provided an opportunity for each student to interview a patient on our inpatient behavioral health unit (BHU), using the "My Story" template.[3] As an introduction to compassion training and the importance of empathy, the group heard a presentation covering the professional identity curriculum used at the Trover Campus.[4,5] The key concept was the recent literature showing that a decrease in empathy comes before burnout rather than the inverse, and empathy requires that the physician keep alive the curiosity that is innate in those choosing medicine. The greatest obstacle to curiosity is the time demands of practice, and this exercise allows the student to understand this first-hand. The focus of the narrative exercise was how the story of the illness sometimes is lost when classification of the disease becomes the primary focus.[6] In my role as medical support to our BHU, I was struck with the remarkable difference between what was recorded under social history by multiple previous physicians in the electronic medical record and one of these student-elicited stories. We share that comparison here.

"Christmas Dinner"

Ms. P shifted in her wheelchair, resting her right hand on her temple as she glanced down at the floor of her inpatient psychiatric room. She told me about how a week earlier – when she was still on the outside – she had tediously fastened the strongest thread she could find around her neck in hopes of breathing her last breath. "I'm too much trouble for everybody," she protested, wincing as the pain of the last 10 years washed over her face. Her hazel eyes, hollowed by a decade of mourning, spoke more vividly than her words ever could.

Life had never been easy for Ms. P, a weathered 77-year-old woman from a nearby town of 2500. Married at the age of 18, she quickly found herself on the receiving end of almost daily physical abuse from her husband who beat her to the point of losing consciousness on several occasions. Her husband, a man whose sole accomplishment was accepting his vast inheritance, was mean-spirited, unforgiving, and seemed to take pleasure in the havoc he created. Despite this, Ms. P stayed with him for over 17 years, even enduring a move to the upper Midwest, several hundred miles away from her nearest family. She did not return home until their divorce, yet during her marriage, isolation was the fondest friend she knew. As time passed, it became her three children that would anchor her to him, but their marriage was sour from the start.

She had always taken pride in her children. They were the dim glimmer of hope that resided in the cold, bleak winters. Even so, one son struggled deeply to process the abuse that his mother had endured at the hands of the man that was supposed to protect their family. It was only a matter of time before he sought reprieve out on the streets, his mere existence encumbered by the vision of his mother cowering in the corner day after day. "I didn't like what he did, but I always loved him," said Ms. P as she described the anguish she felt watching her son turn to drugs and alcohol in the decades to come. Her son was in and out of rehabilitation for a few years, sometimes staying sober for months at a time before he finally scratched the itch like each time before. The crescendo came one quiet morning when Ms. P answered the phone with the same halfhearted disinterest as she had thousands of times prior. Sobbing emanated from the line and in a moment, she knew that her son was gone. The phone fell harshly to the floor with a clatter before gently turning on the laminate tile, the cord twirling back to rest.

The years weighed heavily on Ms. P, yet her son's overdose in 2010 only signaled the beginning of what was to come. A few short years later, she awoke with severe and unrelenting chest pain, quite unlike the pain she had come to know so frequently and intimately over her lifetime as a panic attack. Alarmed, Ms. P went to the nearest hospital and was quickly admitted for treatment of a myocardial infarction – "quickly" being a subjective term in the hospital vernacular as she had already found from previous experience. She had beaten breast cancer in her 40s and knew that "hurry up and wait" was the modus operandi when it came to healthcare. Left with the battle scars of a mastectomy and a few years of chemotherapy, she remained optimistic then about

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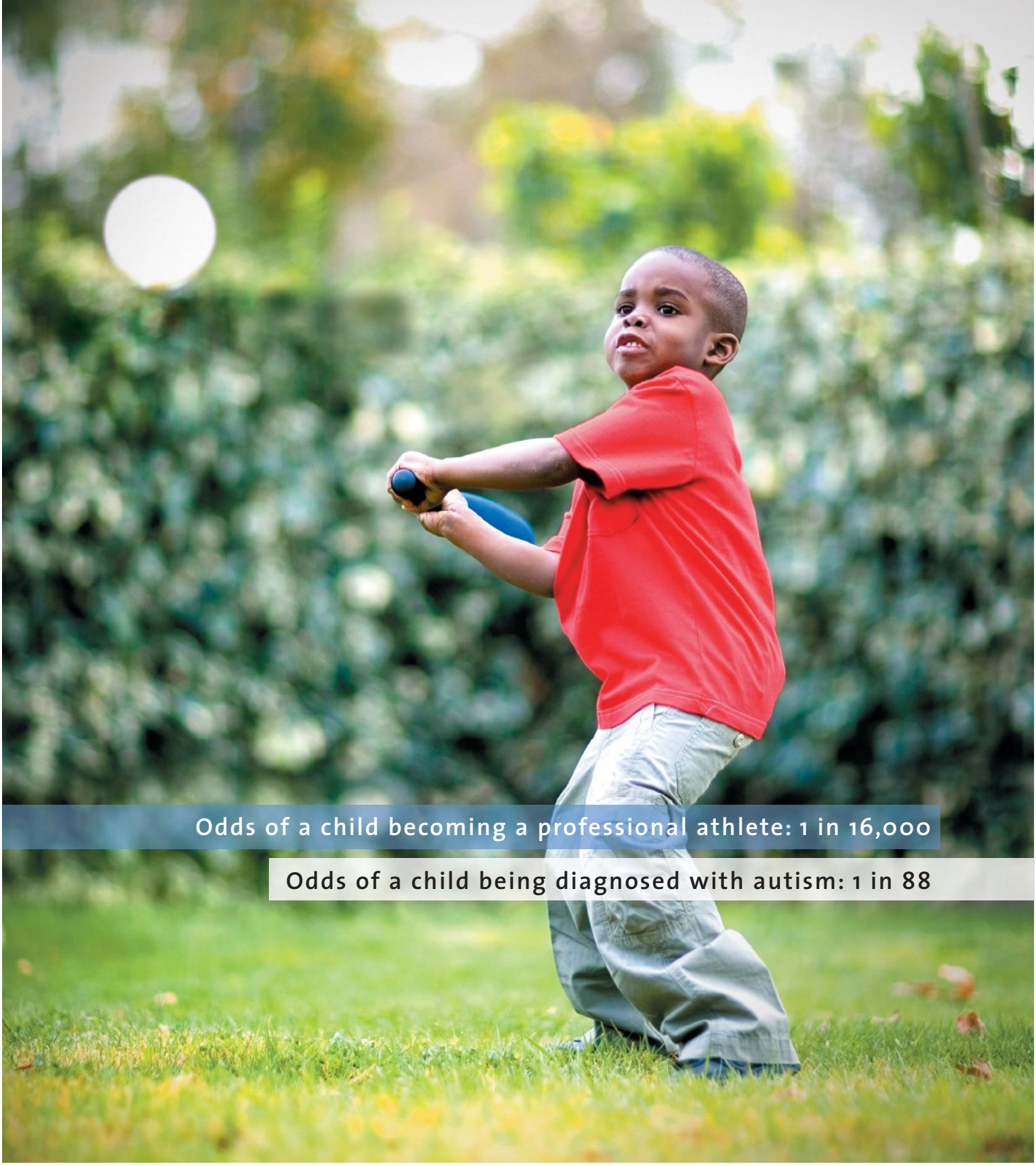

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continued from page 28

her current situation despite the likely difficult road to recovery because, after all, she had won her battle against cancer. Ms. P rested assured that after just a few days in the hospital, she would get back on her feet and normalcy would return.

Instead, every precedent she had ever known was wiped away when in the weeks to follow her left side became numb. Ms. P suffered a debilitating stroke that constrained her to the very wheelchair she sat in before me as I visited her in the psychiatric ward, the life she once knew displaced forever. No longer was she the independent woman whose resilience brought her through abuse, neglect, hardship, and loss. Now, she relied on others to help her perform even the simplest of tasks that she had once taken for granted, each act of care quietly eroding her very soul from the inside out. "That's no reason to live, asking for help all the time," muttered Ms. P, her left arm flaccidly draped at her side. "I want to cook Christmas dinner, clean my house, and play with my grandkids," she went on to say as her eyes welled up with tears.

For her, life amounted to more than a still beating heart or the implication of an unfilled date on her tombstone. Ms. P stopped living when her stroke stole her autonomy and everything since then had been unrequited filler. More precisely, it was not so much that she wanted to die but more so that she had lost the purpose of living amidst her new struggles. The tribulations of her past were nothing compared to a life now lived in half measures.

Eventually, my time speaking with Ms. P ended, but our conversation has laid claim to my thoughts ever since. I cannot shake the visceral sense of both gratitude and desperation. How fortunate was I to have peered into the seven decades of her life with such tremendous honesty and transparency, yet how little of her story might be known to those tasked with taking care of her. It struck me that I might have been the only person that listened to her with no strings attached – no consult pager incessantly buzzing with a dozen other patients vying for my attention or a mountain of orders waiting to be placed in the computer. It was just she and I coupled with as much time as she was willing to lend me. Even the knowledge that my attention resided solely on her as a person rather than as a curious pathology invigorated her, melting away any stale formalities that might have lingered in the air. For the both of us, it felt like a moment of reprieve.

Yet, this is far from the norm. From multiple locations in her chart, her documented social history read, "Divorced, three children." In many ways, efficiency and RVUs are king and time constraints demand a swift pace even if it means that a patient's personhood sometimes gets lost in the process. Thus, Ms. P's entire life story is reduced – even trivialized – to a few words of a social history. This is a tragedy. Through my conversation with her, I have found that a thorough social history not only provides context to a patient's illness, but perhaps even more importantly, it allows the patient a space to express their unique, nuanced, and inherently valuable story.

Ms. P is so much more than a woman who attempted suicide – to label her by such a moment of weakness would be an incredible injustice. Instead, she is something that the medical record cannot show and that her HPI might even contradict. She is a fighter. She has battled for her marriage, her son, her health, and her autonomy. Now, she struggles forward for the simple hope of cooking one last Christmas dinner for her family. Her story has always been there, but Ms. P has shown me, a future physician, that the medical record does not always give the full picture. She is a gentle reminder that so much lies beneath the surface. All I had to do was listen.

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Brandon Dodd graduated from Murray State University with a B.S. in Biology in 2013. He then went on to earn his Master of Divinity degree at the Southern Baptist Theological Seminary in 2018. While in seminary, Brandon worked as a medical scribe before matriculating into the University of Louisville School of Medicine in 2020. He is very interested in skin pathologies and has begun research in the field of dermatology since starting medical school. Outside of school, Brandon enjoys spending quality time with his loving wife of five years and their wonderful three-year-old son.

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