

LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society

**CUSTOM CATARACT
SURGERY CAN ENHANCE
YOUR LIFE**

**How COVID-19 Has Changed
Health Care Delivery**



The Surgery Center of Allentown is a state-of-the-art ambulatory surgery center providing low-cost services and high-quality care for over 10 years.

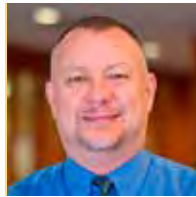
Our services include:

**Colon and Rectal | Ear Nose and Throat | Ophthalmology | Orthopedics
Hand | Sports Medicine | Pain Management | Podiatry**

Our board certified physicians are committed to providing the highest level of personal care in a safe and comfortable environment.



Houman Ahdieh, M.D.
Ophthalmology



Richard D. Battista, M.D.
Orthopedics



Kenneth J. Brislin, M.D.
Orthopedics



David S. Bub, M.D.
Colon and Rectal
Surgery



Irena Cherfas, M.D.
Ophthalmology



Michelle Cintrón, D.O.
Pain Management



Byron M. Cook, D.P.M.
Podiatry



Robert J. Corba, D.O.
Pain Management



Mauricio Figueroa, M.D.
Ophthalmology



Dusty R. Haverly, D.P.M.
Podiatry



Gregor M. Hawk, M.D.
Orthopedics



Christopher A.
Hawkins, M.D.
Orthopedics



Jay V. Kalawadia, M.D.
Orthopedics



Jay H. Kaufman, D.P.M.
Podiatry



Mark Krakauer, M.D.
Ophthalmic Plastic
Surgery



Mark S. Maehrer, D.P.M.
Podiatry



Patrick J. McDaid, M.D.
Orthopedics



Robert C. Palumbo, M.D.
Orthopedics



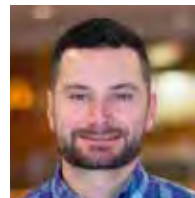
Andrew J. Pestcoe, D.O.
Ear Nose and Throat



Paul F. Pollice, M.D.
Orthopedics



Daniel I. Ross, M.D.
Ophthalmology



Dean L. Sorrento, D.P.M.
Podiatry



Jay S. Talsania, M.D.
Orthopedics



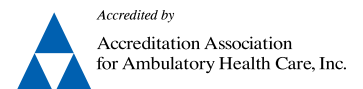
Lawrence E. Weiss, M.D.
Orthopedics



Robert E. Wertz, M.D.
Pain Management

We accept most major insurance plans, including Workers Compensation and High Deductible Health Plans.

To learn more about our surgery center and specialty physicians visit SCOAllentown.com or call **484.268.5232**.



LEHIGH COUNTY Health & Medicine



LEHIGH COUNTY MEDICAL SOCIETY
1620 W Highland St. | Allentown, PA 18102
610-437-2288 | lcmcsoc.org

2020 LCMS BOARD OF DIRECTORS

William A. Tuffiash, MD, PC
President

Bruce D. Nicholson, MD
Immediate Past President Elect

Rajender S. Totlani, MD
Vice President

Oscar A. Morffi, MD
Treasurer

Charles J. Scagliotti, MD, FACS
Secretary

CENSORS

Howard E. Hudson, Jr., MD
Edward F. Guarino, MD

TRUSTEES

George A. Arangio, MD
Wayne E. Dubov, MD
Kenneth J. Toff, DO

EDITOR

David Griffiths
Executive Officer

The opinions expressed in this publication are for general information only and are not intended to provide specific legal, medical or other advice or recommendations for any individuals. The placement of editorial opinions and paid advertising does not imply endorsement by the Lehigh County Medical Society.

All rights reserved. No portion of this publication may be reproduced electronically or in print without the expressed written consent of the publisher or editor.



5 IN THIS ISSUE

ON THE COVER

8 CUSTOM CATARACT SURGERY CAN ENHANCE YOUR LIFE

By Lisa S. Bunin, M.D., Ophthalmologist

12 HOW COVID-19 HAS CHANGED HEALTH CARE DELIVERY

By Mark Wendling, M.D., Executive Director, Valley Preferred

FEATURES

6 THE ROLE OF PUBLIC HEALTH IN OUR COMMUNITY

By Vicky Kistler, Med Director, Allentown Health Bureau

15 HOW LONG DOES A COLONOSCOPY TAKE?

By David S. Bub, M.D., Colon & Rectal Surgery

16 ADDRESSING PHYSICIAN BURNOUT

By Lawrence John, MD, President, Pennsylvania Medical Society

20 ERGONOMIC ADVICE FOR TEMPORARY AND PERMANENT HOME OFFICE SETUPS

By David Blum, PT, DPT

22 DIAGNOSING HIP PAIN

By Elisa Giusto, D.O., Family Medicine PGY-2

24 TALKING WITH YOUR HEALTHCARE PROVIDER ABOUT DOMESTIC AND INTIMATE PARTNER ABUSE

By Turning Point of Lehigh Valley

26 "SHOULD I STAY OR SHOULD I GO?"

By Donna Baver Rovito

28 INGENUITY: THE WORD AND WORK OF THE MOMENT

30 HOW TOP-PERFORMING PRACTICES WILL GROW AND ACQUIRE NEW PATIENTS IN 2020

By Rick Cancelliere



Lehigh County Health & Medicine is published by **Hoffmann Publishing Group, Inc.**
Reading, PA | HoffmannPublishing.com | (610) 685.0914

SEE PAST ISSUES AT LH.HoffmannPublishing.com

FOR ADVERTISING INFO CONTACT:

Tracy Hoffman, Tracy@hoffmannpublishing.com, 610.685.0914 x201

RECEIVE THE LATEST UPDATES BY FOLLOWING US ON SOCIAL MEDIA



What You Need to Know About COVID-19 and Pets

Animals, including pets, can be infected with the virus that causes COVID-19

We are still learning about SARS-CoV-2, the virus that causes COVID-19, but it appears that it can spread from people to animals in some situations. A small number of pets worldwide have been reported to be infected with the virus that causes COVID-19, mostly after close contact with people with COVID-19.

Based on the limited information available to date, the risk of pets spreading COVID-19 to people is considered to be low.

There is no vaccine for SARS-CoV-2

There is currently no vaccine to protect pets or people from SARS-CoV-2. There are vaccines for other coronaviruses in animals, but these do not protect against this virus.

Protect your pet from SARS-CoV-2

Because there is a risk that people with COVID-19 could spread the virus to some animals, including pets, CDC recommends that pet owners limit their pet's interaction with people outside their household and people known or suspected to have COVID-19.

- Keep cats indoors when possible and do not let them roam freely outside.
- Walk dogs on a leash at least 6 feet (2 meters) away from others.
- Avoid public places where a large number of people gather.
- Do not put face coverings on pets. Covering a pet's face could harm them.
- Do not wipe or bathe your pet with chemical disinfectants, alcohol, hydrogen peroxide, or other products not intended or approved for use on animals.

If you get sick with COVID-19, avoid contact with pets and other animals during your illness.

- When possible, have another member of your household care for your pets while you are sick.
- Avoid contact with your pet including petting, snuggling, being kissed or licked, sharing food, and sleeping in the same bed.
- If you must care for your pet or be around animals while you are sick, wear a cloth face covering and wash your hands before and after you interact with them.

Symptoms of SARS-CoV-2 infection in pets

Infected pets might get sick or they might not have any symptoms. Most pets who have gotten sick only had mild illness and fully recovered. Some signs of illness in pets may include fever, coughing, difficulty breathing or shortness of breath, lethargy, sneezing, nose or eye discharge, vomiting, or diarrhea.

Testing pets is usually not necessary

At this time, routine testing of pets for SARS-CoV-2 is not recommended. If you're concerned about your pet's health, work with your veterinarian to ensure that your pet receives appropriate care. If you are concerned your pet is sick after being around a person with COVID-19, talk to your veterinarian. Your veterinarian may want to rule out other more common causes of respiratory illnesses in pets first.

If you think your pet has SARS-CoV-2

If your pet gets sick after contact with a person with COVID-19, call your veterinarian first and let them know the pet was around a person with COVID-19. Some veterinarians may offer telemedicine consultations or other plans for seeing sick pets. Your veterinarian can evaluate your pet and determine the next steps for your pet's treatment and care.

Do not surrender, euthanize, or abandon pets because of SARS-CoV-2

At this time, there is no evidence that animals play a significant role in spreading SARS-CoV-2 to people. COVID-19 is mainly spreading from person to person through close contact. **There is no reason to give up or euthanize pets because of SARS-CoV-2.**



For more information, please visit: <https://www.cdc.gov/coronavirus/2019-ncov/animals/pets-other-animals.html>

[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)



LEHIGH COUNTY MEDICAL SOCIETY
New Members March through May

Mohamed Fouzi Abdul-Hameed, MD
Leonard C Bandala, MD (AN)
Joshua Cassedy, MD (Resident)
Emily P Chea (Resident)
Rebecca Mary Dudley, DO (Resident)
Natalie Elizabeth Ebeling-Koning, DO (Resident)
Rosalia E Hyatt, MD (OBG)
Chideraa N Igabari, MD (Resident)
Rafay Azam Khan, DO (Resident)
Joseph Levi, DO (Resident)
Kasaiah Makam, MD
Anam Malik, MD (Resident)
Shelby McLaughlin-Patel, MD (Resident)
Ahmed Jamal Nadeem, DO (Resident)
Pallav N Shah, MD (R)
Gregory N Singleton, MD (AN)
Andrea Soliman, DO (Resident)
Catherine Zatorski, MD (Resident)
Cecilia Zemanek (Medical Student)

Reinstatement:

Chun Ting Siu (Resident)

IN THIS ISSUE

Welcome to the summer edition of Lehigh Country Health and Medicine. It is hard to believe what we have been through since the spring edition was getting ready for print, which was only a few months ago. Our whole world seems to have changed and we are looking for what will be our new normal. I would like to take a moment to thank all of those frontline workers who are helping all of us during this pandemic.

In this issue we want to introduce you to several new topics, and as you can imagine a few of them center on COVID19.

One article I found particularly interesting, and perhaps ironic, is the piece on the 40th anniversary for the Allentown and Bethlehem Health Bureaus. So far, no celebrations, but thankfully they have been here to support all of us. Once you read more about them, I believe you will be glad for their focus on preparedness in public health.

Telehealth has been around for many years, but until recently, not used to its full potential. As a result of the coronavirus, The Centers for Medicare & Medicaid Services (CMS) broadened access to telehealth services. Please read “How COVID-19 has changed health care delivery” to learn more about how telehealth works. It seems evident that lives may have been saved as a result of this technology.

As many of us who have been able to work are now working from home, take a look at our article on setting up your home office. I found lots of good tips.

June is Cataract Awareness Month, and we think you will enjoy the piece on Custom Cataract surgery; it is very informative. I was surprised to learn that cataract surgery is one of the most common surgical procedures performed in the United States.

We hope you enjoy this and past issues as we add to the conversation about how medicine and wellness can help us form strong communities in Lehigh County. If you are interested in back issues, or just want to read Lehigh County Health and Medicine online, please visit our website at <https://lcmedsoc.org/our-publication>.+



By VICKY KISTLER,
MEDICAL DIRECTOR,
ALLENTOWN HEALTH BUREAU

I guess it is somewhat fitting that the 40th anniversary celebration of the Allentown Health Bureau was cancelled due to a pandemic. After all, local public health has been trying to convince people to prepare for decades. It is doubtful that anyone could have been prepared for the situation we are facing in response to COVID-19 but we certainly could have been in a better position and hopefully lessons learned won't be forgotten easily when life returns to whatever the new normal brings.

The Allentown Health Bureau was created when the Bi-City Health Department (Allentown and Bethlehem) divided in 1980 over the issue of fluoridating the water supply. With no agreement the separate Allentown and Bethlehem health bureaus were created. Local health departments were always charged with disease investigation and containment, however, it really was not

until the terroristic attack of September 11, 2001 that local health departments became active and immersed in public health preparedness activities. It was in those days and in response to a certification program called Project Public Health Ready (PPHR) of the National Association of City and County Health Officials (NACCHO) that a partnership solidified between Emergency Management teams and public health.

Many drills and exercises have been held attempting to plan for all sorts of weather-related emergencies, active shooter situations, and acts of terror. It was the responsibility of public health to remind the first responder community that widespread illness can be just as debilitating and can have long lasting effects on a community. It is through these drills and exercises that relationships have been formed between law enforcement, fire departments,

THE ROLE OF PUBLIC HEALTH IN OUR COMMUNITY



coroners, emergency medical services, local emergency management, hospital staff and administrators and local public health officials. During these times it is those relationships that create the partnering strength necessary to support each other through the pandemic. It is an example of the strength of an area if agencies work together toward a common goal.

In the City of Allentown, we are proud of the team that has been created. Daily calls scheduled by a liaison with the Hospital Association of Pennsylvania bring the partners together to touch base on each agency's role and status update during COVID-19. It is during those calls that the Allentown Health Bureau discusses the trends being seen in patient interviewing and contact tracing. The outbreaks in employment sites, long term care facilities, etc., are shared and the strategies for containment are discussed. The first responder community is apprised of local conditions.

The role of public health is behind the scenes – often regulatory – often misunderstood or forgotten, but right now, in the middle of COVID-19, it is pivotal. Strong contact tracing and social distancing measures are the best defense we have until an efficient vaccine and effective medications are widely available. The role still is not very visible but citizens wearing masks, an effective public health measure, are. It is my hope that the dedicated workers at the Allentown and Bethlehem Health Bureaus get to celebrate the 40th anniversary soon but in the meantime, we will just keep fulfilling our mission – protecting the public's health.+

CUSTOM CATARACT SURGERY CAN ENHANCE YOUR LIFE WHICH CHOICE IS RIGHT FOR YOU?

By LISA S. BUNIN, M.D., OPHTHALMOLOGIST

Cataract surgery has undergone tremendous technological advances since the days of your parents and grandparents. This year, millions of patients will choose to have both their vision and their lifestyles improved, thanks to this life-changing surgical procedure.

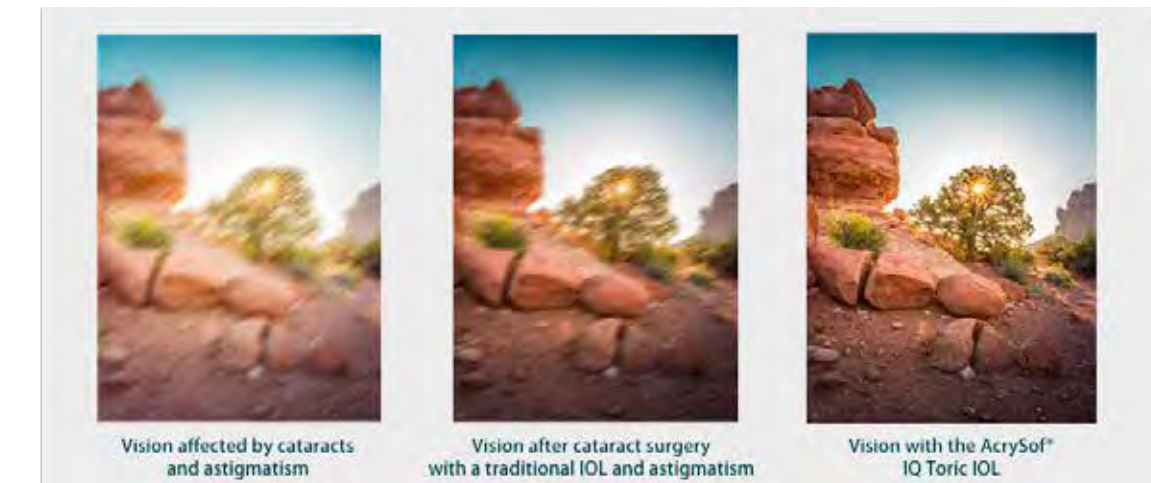
WHAT IS A CATARACT?

A cataract is a “clouding” of the natural lens inside your eye, keeping light from reaching the retina. A cataract can be the reason sharp images become blurred, bright colors become dull, or seeing at night or in the rain is more difficult. It may also be why your glasses no longer seem to help. Cataracts can cause very gradual changes in vision, or can grow quickly,

causing vision changes over weeks to months. Most patients tell us they didn’t know what they were missing until they had their first cataract removed!

WHO PERFORMS THE SURGERY?

While there are different eyecare professionals called “eye doctors,” only an Ophthalmologist (eye surgeon MD) can perform surgery. Ophthalmologists have had vigorous training for eight or more years after college, and this is very specialized surgery.



Monofocal IOL without astigmatism corrected



Monofocal IOL with astigmatism corrected (Toric IOL)

NEW TECHNOLOGY FOR SURGERY AND IMPLANTS: STATE OF THE ART

Cataract surgery is one of the most common surgical procedures performed in the United States. It is typically an outpatient procedure requiring only a small amount of time. You will be made “sleepy” through IV medications and will be very comfortable. Most surgeons use topical anesthesia, so you don’t even have to stop aspirin or coumadin! Patients are generally able to return to their daily activities shortly after their cataract surgery. We perform cataract surgery on one eye at a time, typically a week or two apart.

The cataract incision used to be larger and required stitches. Now we enter the eye through a tiny self-sealing incision, made with a diamond blade or pre-marked with a femtosecond laser. We can correct moderate amounts of astigmatism through small incisions near the periphery of the cornea (limbal relaxing incisions) done with a diamond blade or the laser, or by using a special astigmatism-correcting Intraocular lens implant (a Toric IOL) inside the eye for larger amounts of astigmatism.

Continued on page 10

FEATURE

When the cloudy, cataractous lens is removed at surgery, a new artificial lens (intraocular lens implant) is put in the eye to help focus the light. In the past we just took out the cataract and then waited a month for the eye to heal and then prescribed new glasses that matched the new refractive error for distance vision (near-sighted, far-sighted, plus astigmatism). And everyone needed reading glasses or bifocals after surgery no matter what age they were.

Today cataract surgery is an opportunity for improved vision and a decrease in dependence on glasses!

Intraocular lens technology has taken a giant leap forward. No longer is the objective simply to improve your cloudy vision. Today, the goal is to enhance your new vision with an enhanced optics intraocular lens (IOL) that may provide you with a full range of vision, thus minimizing your dependence on reading glasses or bifocals, and reducing any astigmatism. We offer Toric IOLs or limbal relaxing incisions (LRIs) to correct astigmatism and aim for good distance vision without glasses, and we also offer lenses that can correct distance, middle, and functional near vision without glasses (Multifocal or Extended Depth of Field IOL's).

Customizing the type of upgraded lens and procedure to YOUR eye and your visual needs is called CUSTOM CATARACT SURGERY.

Custom Cataract surgery can enhance your life... Which choice is right for you?

Your vision is precious and having the highest quality vision is priceless! Improved vision supports a vibrant lifestyle. Optical quality has improved in our televisions, cameras and smart phones, so you should expect the same level of technology improvement for your eyes.

We now offer new lens implants with “high definition” optics that focus light more sharply with fewer aberrations than older lenses, giving superior quality of vision. We offer new lenses and procedures to reduce astigmatism. And we have multifocal lens implants, which provide better vision for distance, mid-

range, and reading without glasses most of the time. These improvements give you far better vision quality and a higher quality of life than a standard implant can.

These upgraded lenses and procedures must be customized for your eye. Upgrades require additional testing, advanced calculations, and additional pre- and post-op care than standard implants do. The good news is that your medical insurance will pay for the medical part of the surgery, the anesthesia, and the facility fee; you are only responsible for the upgrade package costs (and any deductibles or copays you may have based on your insurance plan). Your doctor and staff will go over all your options with you and answer all of your questions, helping you to choose the right option for you.

WHAT CAUSES A CATARACT?

A cataract is not a “film” over the eye, and neither diet nor lasers will make it go away. A cataract is a “clouding” of the natural lens inside your eye. The human lens, made mostly of protein and water, can become clouded – so clouded it keeps light and images from reaching the retina. Eye injury, certain diseases, or even some medications can cause the clouding. But, in over 90% of cases, clouding is caused by the aging process and exposure to UV light over your lifetime. Clouding of different parts of the lens can affect your vision in different ways.

SYMPTOMS OF CATARACTS

A cataract can be the reason sharp images become blurred, bright colors become dull, or seeing at night is more difficult. People with cataracts have more trouble seeing clearly at dawn, dusk, in the rain, or in bright sun or snow, and have more car accidents. It may also be why the reading glasses or bifocals that used to help you read, or do other simple tasks, no longer seem to help. Cataracts can develop slowly, causing very gradual changes in vision, and patients adapt by limiting activities that they once enjoyed. Most patients tell us they didn't know how much they were missing until they had their first cataract removed!

YOUR VISION IS PRECIOUS AND HAVING THE HIGHEST QUALITY VISION IS PRICELESS!

FACT: Wearing bifocal glasses increases your risk of falling and breaking a hip by 6 times!
(Falls are the leading cause of death from injury among older adults in the US).

FACT: Your vision becomes MORE important as you age, because your hearing and mobility diminish.

FACT: Cataracts increase your risk of being in a car accident 6-8 times!

WHO DEVELOPS CATARACTS?

Almost everyone will develop cataracts over their lifetime. Typically, people over 50 have some degree of cataract, and most people over age seventy have significant changes from cataract that affect their daily functioning, particularly driving—yet they may not be aware of the changes if they happen slowly.

TREATMENT OPTIONS FOR CATARACTS

If your cataract has not matured to the point of interfering with your ability to safely perform your daily activities, we may just want to monitor the cataract's progression with regular check-ups, and more frequent changes in your eyeglass prescription to refocus your eyes. If stronger glasses or an antireflective coating on the glasses will help, we prescribe those for you. But unfortunately, cataracts are progressive and cannot be prevented. Removing the cataract and replacing it with an artificial lens may improve your vision and, in many ways, significantly improve your quality of life.

WHEN SHOULD I HAVE MY CATARACT REMOVED?

Modern techniques have made cataract surgery much safer, so the time to have your cataracts removed is when the quality of your vision begins to put limits on your activities and enjoyment of life. We do NOT wait until cataracts are "ripe" to remove them—that's the old way. Newer techniques are faster and safer and done without stitches. We use high speed ultrasound to chew up the cataract. Waiting till the cataract is hard doesn't benefit your cornea and macula, because there's an increased swelling risk when more power is needed to chew up the cataract.

With all the new upgrades available to improve the quality of your vision and reduce your astigmatism, most of our patients tell us they wish they had had cataract surgery earlier! +

Patient testimonials: Hear what patients are saying after custom cataract surgery:

Sara T.: I am so happy with my new vision!! I can see to thread a needle, work on my computer, paint, and drive – all without glasses – since my doctor removed my cataracts and put multifocal implants in my eyes. I never realized what a burden glasses were till they were gone! My friends are jealous when I don't need glasses to read the menu, and I feel secure walking up and down stairs. Now my son wants to have his cataracts out. Thank you doctor!!

Dave M.: I had astigmatism all of my life, and could never see as clearly with my left eye, even with glasses. Then my doctor removed my cataract and put a Toric lens implant in my eye, and I can't believe the difference!! It's a whole new world – things are no longer distorted or tilted, and the colors are amazing! I can drive and play golf without glasses. I would recommend this to anyone.

Rich P.: I was so near sighted that I couldn't see my feet or find my way out of the ocean by myself without glasses. Since my cataract surgery, I can do it all – without glasses! It's better than Lasik, because I can see near as well as far. It was well worth the extra cost to have the multifocal implant.

Frank S.: I didn't realize I had cataracts because the change was so gradual, but after the first cataract was removed I was embarrassed – as a TV repairman I had been telling people they needed new color tubes, when the real problem with light and color perception was due to my eyes! What an amazing difference it was! My doctor gave me the new "high-definition TV" lenses and corrected my astigmatism, and now my buddies call me "eagle eye!" My only regret is that I didn't do it sooner.





How COVID-19 Has Changed Health Care Delivery

Has telemedicine taken its place as an emerging standard of care?

By MARK WENDLING, MD, EXECUTIVE DIRECTOR, VALLEY PREFERRED

“To manage COVID-19, health care systems and physicians’ practices had to ramp up telemedicine capabilities quickly to protect staff and care for patients. Those that adopted telehealth will find the benefits extend beyond this current situation, because there will assuredly be other long-term needs, and patients seem to like it.”

– Joe Tracy, Vice President, Connected Care and Innovation, Lehigh Valley Health Network

Suddenly and swiftly, health care providers found themselves grappling with a pandemic and government mandates for people to stay at home. They had to retool, and fast. They turned to technology, and specifically video visits, to not just limit exposure of patients and staff to the virus, but also to conduct regular or urgent visits during this unprecedented time of mass quarantine. The involuntary experiment in telemedicine worked out well from many accounts, but does it imply a robust future for “staying at home and seeing your doctor”?

A SLOW RISE TO ACCEPTANCE

Even though telehealth has been a part of health care for about 27 years, it wasn't received with open arms by all in the medical or payer community. Smaller practices were reluctant to make investments in technology, as legislation made it difficult and insurance companies did not always provide payment for these services. Then COVID-19 came along and changes were swiftly operationalized.

The Centers for Medicare and Medicaid Services (CMS) expanded its benefits on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. According to CMS: Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patients' places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Most commercial payers have passed similar temporary provisions, such as waiving telemedicine fees for any condition, offering virtual evaluations and monitoring visit benefits to all fully insured members, and giving members zero cost-sharing for telehealth urgent care services. These provisions vary by plan and by state but have served to facilitate the use of technology for an increasing number of visit types as the pandemic unfolded.

A LOOK AT HOW TELEHEALTH WORKS

Telehealth visits (video encounters are the most common under the umbrella of telehealth) use high-definition video conference devices that also allow connection of medical instruments. Typically, in the inpatient setting, the technology is housed on a cart, and the physician makes a call to the cart. The patient exam takes place via a camera that can examine the patient up close. It's possible to look in eyes,

ears, nose, and throat, and listen to the heart and lungs with an electronic stethoscope. The physician also has access to the patient's medical records during the exam for history and updating. Under COVID-19, the use of tablet technology for providing telehealth services has also come into play and has expanded quickly, thus giving providers and patients more options to connect with each other.

Under normal circumstances the software that is used has been vetted for privacy and security. Hospitals often maintain a patient portal for access. In that case, everything is embedded. However, since COVID-19, regulations have been relaxed, as some individual practices are conducting visits using FaceTime, Skype, and other platforms. During this unprecedented time, patients have been simply making a call to their provider with a cell phone.

THE TECHNOLOGY BECOMES LIFE-SAVING

The fact that this technology was available and adaptable was helpful in several ways during the pandemic. The first, in most simple terms, was to be able to screen patients remotely rather than have them visit the doctor's office in person. With a virtual triage, patients with cold or flu-like symptoms, if deemed appropriate, could be cared for remotely or quarantined at home. This way, potentially infected people were kept away from the hospital and doctors' offices, protecting providers and their staffs, keeping transmission low, and ensuring the safety of patients with chronic diseases who were at high risk if exposed to the virus.

Similarly, telemedicine allowed first responders in the field to communicate with emergency department (ED) doctors, helping to ensure those who needed hospital care got it quickly and efficiently. At the same time, they were able to divert those who didn't need hospital care to other facilities or keep them safe at home. Often, this type of preparatory communication results in a substantial reduction in transfers to other facilities, and a reduction in ambulance coverage costs.

GOING FORWARD POST-PANDEMIC

A new perspective on health care delivery may be valuable as hospitals and physicians begin to gradually ease back into a sense of normalcy. To assist, it's helpful to refer to positives in areas where the technology has already made inroads, and could continue after the crisis abates. These include remote patient monitoring, tele-mental health services, and in burn center programs, where digital photography is used to remotely determine whether someone needs to be an inpatient, outpatient, or if he or she can travel at all.

Continued on page 14

The ICU has benefited extensively from telemedicine. While many hospitals have intensive care physicians on-site during the day and into the evening, technology ensures that that coverage extends 24 hours a day. Monitors watching patients overnight feed the medical record in short intervals of time, and alert nurses and doctors if vital signs are abnormal. Health care providers are kept safe if an infectious disease like COVID-19 is involved. By using telemedicine technology in this way, one local hospital cut mortality rates among its ICU patients by 31%.

Another area where telemedicine has been shown to be valuable in caring for COVID-19 patients is in the emergency department, where patients are able to be triaged virtually using cameras like those described in the previous section. The patient will see the ER physician virtually at first, to get an idea of the nature of the problem and take vital signs. The ER physician will then visit the patient in person, knowing that the virtual encounter maximized the efficiency of the exam and reducing exposure time for both provider and patient. Adopted widely during the COVID-19 crisis to reduce exposure of health care providers to the virus, this method is valuable in time savings, and reducing the chances patients will leave the ED without being seen.

Under any circumstances, from a global pandemic to business-as-usual, telemedicine accomplishes something that can be positive for any health system or physician's practice: It eliminates the geographic barriers and equals the playing field in terms of access to care. For example, if a patient with a neurological concern lives in a rural area and the local hospital has no neurologist on staff, he or she can see one at a larger hospital remotely without having to travel there in person. Such an avenue serves to ensure that people who may be inclined not to seek care for a condition "out of the realm" of the local provider, will now do so.

WHAT IS AHEAD?

Telemedicine will never be a panacea. There is truly no replacement for the in-person visit with a physician or mental health professional. Even so, the potential for telehealth in the scheme of health care delivery, demonstrated so boldly during the COVID-19 crisis, is great.

Physician acceptance and adoption of telehealth continues to rise, and the medical community is advocating for the current change in regulations to last. In fact, many believe growth of telehealth as a modality can only occur with continued relaxation of requirements, an expanded list of people who can provide telehealth, and growth in the list of treatments and conditions that can be reimbursed.

If COVID-19 were a learning experience, government and insurance payers may have realized the value of telehealth in terms of overcoming barriers to access, keeping patients safe from infection, and providing a convenient alternative to routine in-person care. We just have to wait and see whether that realization will influence policy. Moreover, it will be fascinating to view how the technology is utilized in innovative ways in the future. +



FEATURE

How Long Does a Colonoscopy Take?

By DAVID S. BUB, M.D., COLON & RECTAL SURGERY

So, do you know the facts about colonoscopies – or just the myths? Read on as we dispel the falsehoods and arm you with the facts about colonoscopies.

Myth: Colonoscopies take too long.

Fact: A colonoscopy procedure takes only 30 minutes.

Colonoscopies do not “take all day,” but it’s certainly understandable why people circulate this myth. The procedure itself takes only 15-30 minutes, but the colonoscopy prep and pre-op/post-op time commitment makes the procedure seem much longer. However, when you consider the years (or even decades) a colonoscopy can add to your life, the time spent on this life-saving procedure comes into perspective.

It may be tempting to opt for alternative colon cancer screening tests. However, a colonoscopy offers significantly more health benefits for similar cost, making it the recommended screening for colon cancer detection and prevention. Moreover, it’s the only colon cancer screening method that actually prevents cancer by allowing your doctor to remove precancerous colon polyps during the procedure. All colon cancer begins as a polyp, so no polyps mean no cancer! No test besides a colonoscopy can prevent you from getting colon cancer.

The Facts About Having a Colonoscopy

Everyone loves a good story with exaggerated details for humor and emphasis, but colonoscopy tales tend to lose credibility as they circulate. The best way to bust myths is to know the facts. Here are the facts regarding the steps of a colonoscopy and why each step is important:

Before the Colonoscopy

Staying colon cancer-free requires some work on your part, and that is the bowel preparation, also referred to as colonoscopy prep. Proper bowel prep is essential for an effective colonoscopy. For a full colon cleanse, you will need to follow the detailed instructions included in your bowel prep kit. You’ll need to adhere to a clear liquid diet in the hours prior to your colonoscopy. You can have some approved treats with specific restrictions. And there are ways you can make colonoscopy prep easier.

During the Colonoscopy

You should plan on spending two to three hours at your outpatient GI center on the day of your colonoscopy. You will need to arrive early for your appointment so you can check in and fill out paperwork. Once the nurse calls you back, the procedure will move along quickly. Most colonoscopies are performed with anesthesia or sedatives that put you to sleep, so you won’t even remember the procedure.

While under anesthesia, your GI doctor will examine the length of your colon for any signs of colon cancer or other diseases of the digestive system. At that time, the doctor will remove suspicious polyps to reduce your risk of cancer.

After the Colonoscopy

You will feel a little groggy upon awakening, but once you’re alert, you will get dressed and meet with your doctor to briefly go over your results. If no polyps are found and you have no family history of the disease, you won’t have to come back for another ten years.

A family member or friend must drive you home. The good news is that you can spend the rest of the day resting and eating a normal diet. The sedative will continue to wear off throughout the day, and you will be able to return to work the following day.

24 hours for 10 years

Is 24 hours of your time worth 10 years of good health? When you look at it that way, is it really even a question? Don’t let myths drive your healthcare decisions. If you have questions about how a colonoscopy is done or when to get a colonoscopy, ask your colorectal surgeon.





Addressing Physician Burnout

By LAWRENCE JOHN, MD, PRESIDENT, PENNSYLVANIA MEDICAL SOCIETY

This article was reprinted with permission from the Pennsylvania Medical Society.

This is a picture of Fallingwater – an architectural wonder designed by the iconic architect Frank Lloyd Wright and built in the magnificent western Pennsylvania mountains. Fallingwater is a masterpiece of amazing balance. Wright’s design exhibits awesome beauty and stability constructed in the face of compelling obstacles.

Fallingwater meets the challenge of being built over a waterfall and nestled within the forest, developing a harmony between man’s design and nature. This home is built on the principle of a crucial balance. At the same time that Wright was seeking balance in his designs, he spoke emphatically about achieving goals.

In this era of modern medicine, we see physicians striving to overcome many challenges in order to create an environment that is balanced and rewarding. We have dedicated our lives to serving our patients and ensuring their health and well-being. Now it is time for us to listen to ourselves and our colleagues to ensure our health and well-being.

One important issue which requires our attention is physician burnout. It must be part of our conversation now and well into the future. Many studies reveal growing evidence that physicians feel burned out. According to Medscape’s 2020 National Physicians Burnout and Depression Report, more than 40 percent of physicians are burned out. More than 15,000 physicians in more than 29 specialties responded to Medscape’s survey.

Given these statistics, it is critical to have the conversation now to increase awareness and enhance communication regarding physician burnout. We need to clearly identify the elements contributing to physician burnout and, at the same time, attempt to develop new ways to support resilience and strength within our profession.

HOW DID WE GET TO THIS POINT?

Physicians are constantly asked to perform many demanding tasks without the needed support to accomplish them. We all can identify with the struggles and demands that electronic health records have created in our daily lives. We all have felt isolated. We all know how difficult it is to not be heard by employers, the government, and insurance companies.

Studies have identified a multitude of factors that contribute to physician burnout. You can certainly relate to some of these factors, such as:

- Spending time on the phone with prior authorization peer-to-peer appeals instead of spending time in an exam room with patients
- Losing sleep over paperwork, patient satisfaction ratings, RVU requirements, quality measures, MIPS, and MACRA

When asked why, Wright said, “You have to go wholeheartedly into anything in order to achieve anything worth having.”

Continued on page 18

FEATURE

- Pajama Time at night completing patient notes with your computer instead of quality time with your family
- A sense of loss of control with the demands of an overwhelming workload

Since we all know that a physician's work can certainly be very rewarding and personally satisfying, now we all must help each other seek a balance with our professional demands and personal lives.

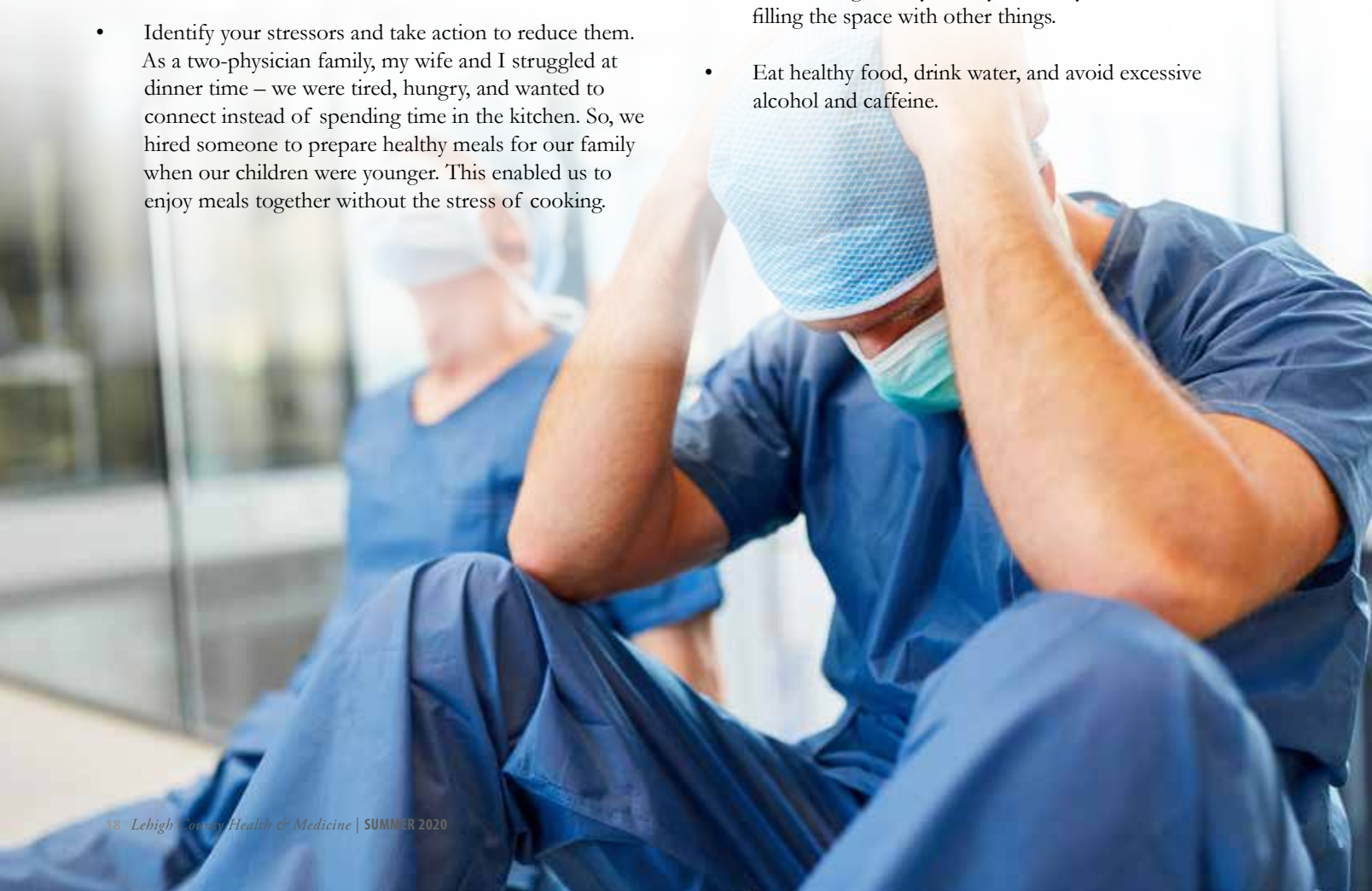
HOW CAN WE ACHIEVE WELLNESS AND RESILIENCY?

On an Individual Level

On an individual level, burnout is recognizable, reversible, and treatable. From a personal perspective, there are steps we can all take to address stress and anxiety, such as:

- Be a part of organized medicine, such as the Pennsylvania Medical Society and your county medical society, so we can stand with a united voice as the government and insurers continue to edge into our exam rooms.
- Identify your stressors and take action to reduce them. As a two-physician family, my wife and I struggled at dinner time – we were tired, hungry, and wanted to connect instead of spending time in the kitchen. So, we hired someone to prepare healthy meals for our family when our children were younger. This enabled us to enjoy meals together without the stress of cooking.

- Unplug from technology and connect with loved ones. Keep a good balance between work and home by spending time with family and friends doing things you enjoy.
- Get enough sleep. Set a bedtime and honor it, realizing that you can finish what you were working on tomorrow.
- Take mindful minutes throughout the day. Doing a few yoga poses, a 10-minute meditation, listening to your favorite music, and taking a few deep breaths can give you a quick reset. Try things out to see what works best for you.
- Cultivate interests outside of medicine. Take up a new hobby, volunteer, start a second career, plan fun events, or read non-medical materials.
- Build physical activity into your daily routine. Movement increases your energy, releases stress, and improves your mood.
- Set aside time to do nothing. Schedule a few minutes of “nothing” into your day to clear your mind and avoid filling the space with other things.
- Eat healthy food, drink water, and avoid excessive alcohol and caffeine.



On an Organizational Level

Organizational involvement is key in re-engaging physicians and reversing the trend in burnout. There are many things organizations can do to address burnout, including:

- **Get organized**
 - Educate and increase awareness
- **Assess your needs and prioritize**
 - Designate time for reflection
 - Identify your organization's core values
 - Envision your organization's culture
- **Anticipate obstacles**
 - What resources do you have?
 - What's realistic for your organization?
 - What do you need to foster employee buy-in?
- **Engage leadership**
 - Teach practical skills
 - Build community
 - Incentivize physicians to get involve

- **Stay accountable**
 - Improve workplace environment, promote flexibility and work-life integration
 - Provide resources to promote resilience and self-care
 - Keep talking about it – make it a continued priority, not a once-and-done discussion

During my presidency, I will continue to work with PAMED leadership and staff to provide resources and education that can help you determine the best ways to mitigate signs of burnout. The solutions will require more than yoga and mindfulness training, although these are effective practices for some of us. I invite you to join in the conversation at www.pamedsoc.org/wellness.

Frank Lloyd Wright once said: "We are all here to develop a life more beautiful, more concordant, more fully expressive of our own sense of pride and joy than ever before in the world." +

FAST FORWARD

Document Solutions

With dedicated
specialists in
healthcare
document
management

Edwards
Business Systems

65+
Years

2240 City Line Road • Bethlehem • 610.266.0200
edwardsbusiness.com

Ergonomic Advice for Temporary and Permanent Home Office Setups

By DAVID BLUM, PT, DPT

With people suddenly and unexpectedly working from home in the wake of the COVID-19 pandemic, many have had to set up creative home “office” arrangements. Whether you’re working from your kitchen table, ironing board or a dedicated home office, proper ergonomics will maximize productivity and comfort and reduce your risk of injury. The following are some tips for creating a home office that is both ergonomic and comfortable.



Computer Setup

The computer screen should be placed an arm's length away, with the top of screen at eye level to ensure proper head, neck and back alignment.

Your keyboard should be situated at or slightly below elbow level. Meanwhile, your arms should be supported at your side comfortably. Armrests or other arm support should be high enough for your elbows and forearms to touch the surface. However, they should not be so high that they cause your shoulders to shrug upwards.

Your wrists should be straight and supported by your work surface or other support; a rolled up towel can help.

Suggestions for Sitting and Standing

When sitting, your chair should be at a height where your knees are level with your hips and your feet are flat on the floor. Use something under your feet, such as a textbook, to level your hips.

Your chair should be comfortable and supportive. Try to avoid hard wooden or soft lounge chairs. Use a lumbar support pillow or a rolled up towel behind your low back if needed.

If standing, stand on a supportive mat or wear comfortable sneakers to improve comfort.

General Home Office Ergonomic Tips

Use a headset, Bluetooth attachment or speaker phone for phone calls while typing to avoid maintaining a flexed or bent neck position for extended periods of time.

If able, use a separate keyboard attachment for your laptop to improve screen and keyboard setup.

Get creative with materials around the house. Use towels to boost armrests or a book to raise your computer screen height.

Pain Treatment Options Now Include Telehealth

If you're experiencing pain or strain from your new teleworking setup — or any other condition — physical medicine and rehabilitation can help address and prevent recurring problems in your back, neck, shoulders, knees and more.

In fact, in response to COVID-19, many area health-care providers — including Good Shepherd Rehabilitation

Network physicians, physical therapists and occupational therapists — are now offering virtual visits for adult and pediatric patients experiencing pains and strains. Through telehealth video visits, a patient in need of pain relief can communicate with a physician or a physical therapist via smartphone, laptop, desktop or tablet. You can be evaluated by a licensed professional and receive care, including guided exercises and stretches, all from the safety and comfort of your home.

Personally, I have treated patients who were unsure of telehealth, its benefits or how the technology works. Not only have they come to enjoy it, telehealth has allowed us to relieve their pain during an uncertain time.

These tips and pain-treatment options can help maximize your temporary or permanent home setup to be the most comfortable, safe and ergonomic possible. +

David Blum, PT, DPT, is a physical therapist at Good Shepherd Rehabilitation Network's Health & Technology Center in Allentown. He specializes in orthopedics, including post-surgical, sports rehab and pain management.



DR. JOHN G. KUNA & ASSOCIATES
PSYCHOLOGICAL AND COUNSELING SERVICES

*Listening,
 Learning,
 Understanding*

EVENING/WEEKEND APPOINTMENTS AVAILABLE
MOST INSURANCES ACCEPTED
12 CONVENIENT LOCATIONS

DRJOHNGKUNA.COM

570.961.3361

D
I
A
G
N
O
S
I
N
G

HIP PAIN

By Elisa Giusto, D.O., Family Medicine PGY-2

The approach to diagnosing hip pain in adults includes 5 steps:

- 1. Determine if the pain is related to trauma:**
Even minor trauma, like a fall from a chair, can cause a fracture of the hip or pelvis in a frail, older adult. Examination of a patient with a fracture may reveal difficulty with weight-bearing, anterolateral hip tenderness, and significant pain with passive hip motion, especially internal and external rotation. Plain radiographs of the hip may not reveal such a fracture so the patient must remain non-weightbearing if the diagnosis is suspected until CT, MRI, or serial examination of the hip rules out the diagnosis.
- 2. Determine if a dangerous medical condition is the cause:**
Aortoiliac arterial insufficiency can present with achy pain or claudication in the buttock, hip, and occasionally the thigh. Examination may reveal arterial bruits and diminished groin or distal lower extremity pulses.

Septic arthritis usually affects older adults with systemic medical problems such as diabetes or who are otherwise immunocompromised. Examination may reveal localized warmth, redness, or swelling of the hip joint, but these signs are often absent because of the depth of the hip joint.

Osteonecrosis is most often progressive and causes destruction of the hip joint within three to five years. It is more common with glucocorticoid use and excessive alcohol intake. Pain generally occurs with weight-bearing, at rest, and at night.

Bone tumors usually presents with localized pain that may wax and wane with soft tissue swelling. Systemic symptoms such as weight loss or night sweats raise suspicion for malignancy.

3. Determine if osteoarthritis or rheumatologic disease is the cause:

Osteoarthritis of the hip typically presents with pain of insidious onset that is felt deep in the anterior hip or groin, exacerbated by activity, and relieved by rest. There may be anterior hip tenderness, reduced hip motion in multiple planes, and pain with both flexion, adduction, and internal rotation (FADIR) and flexion, abduction, and external rotation (FABER/Patrick). Normal articular width of the hip joint is 4 to 5 mm; marked narrowing of the joint space, sclerosis of the joint space margins, and periarticular osteophyte formation are consistent with osteoarthritis on radiographic imaging.

Rheumatoid arthritis spondyloarthritis such as psoriatic arthritis or reactive arthritis and crystal arthropathies such as gout or pseudogout usually involve multiple joints, other organ involvement, and family history of rheumatologic disease. It is important to look for rashes, nodules, and eye changes such as iritis. Consider ordering a CBC with diff, CRP or ESR, Rheumatoid factor, HLA-B27, and ANA.

4. Determine if radiculopathy or nerve entrapment is the cause:

Compression of lumbosacral nerve roots or of peripheral nerves can manifest as hip pain. Hip pain referred to the proximal, lateral thigh or accompanied by weakness suggests lumbar radiculopathy. Symptoms may be reproduced by active motion of the lumbar spine or neural testing such as the seated slump test.

Nerve lesions at the sacroiliac joint may refer pain to the gluteal region. Provocative testing with supine hip posterior thrust or lateral pelvic compression exacerbates symptoms. The lateral femoral cutaneous nerve is a pure sensory nerve that courses from the lumbosacral nerve plexus, through the abdominal cavity, under the inguinal ligament and into the subcutaneous tissue of the thigh. Entrapment of this nerve causes burning pain or paresthesia localized to the superior and lateral thigh.

5. Determine if the pain is local, suggesting a discrete musculoskeletal diagnosis:

Lateral hip pain is nearly always localized to the region immediately superior to the greater trochanter and may radiate down the thigh to the lateral knee along the iliotibial band.

Anterior hip pain is often due to hip joint pathology, although pain of acute onset may be due to labral injury, proximal hip flexor muscle strain, or iliopsoas bursitis. Femoroacetabular impingement produces anterior hip pain that is often worst when the hip is moved to the ends of its range of movement, especially internal and external rotation. Pain localized to the region of the adductor tendon origins may indicate adductor tendon pathology or referred pain from osteitis pubis.

Pathology within the posterior hip joint such as labral tears, synovitis, or chondral injuries can refer pain to the buttock or lower back, although proximal hamstring pathology, piriformis syndrome, sacroiliac joint pathology, and lumbar radiculopathy from the L5 to S1 levels must be considered.+

Source: https://www.uptodate.com/contents/approach-to-the-adult-with-unspecified-hip-pain?search=hip%20pain&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Talking with Your Healthcare Provider about Domestic and Intimate Partner Abuse

By TURNING POINT OF LEHIGH VALLEY

“It’s been a long hard road, but I know I see the light at the end of the tunnel!!! Thank you so much for giving me hope and my life back.” – Safe House Resident

Chances are if your partner is abusive, you probably do not get a lot of alone time. We know that one of many common tactics of abuse besides power and control is isolation. If your partner has isolated you from your family, friends, and the community, your healthcare provider might be one of the only people that you have the opportunity to speak with alone. Please consider speaking to them about any abuse that you may be experiencing since they are concerned with both your physical and mental well-being.

If your abusive partner insists on attending your medical appointments with you, we know it is not easy to simply ask your partner to stay in the waiting room or say no when the nurse asks if you want your partner to come back with you. It can be a fine line asserting your right to privacy during your appointment in front of your partner. If you speak up, it could make things worse and you could potentially be less safe after you leave the appointment. Trust your instincts since you know your abuser better than anyone. Your safety is of the utmost importance.

“I remember standing in an elevator with a big smile on my face.

Someone asked me, why are you smiling? I said, I’m finally safe and happy.” - Jan

Here are some options that you can consider prior to any medical appointment when you meet with your healthcare provider alone and away from your abuser during an appointment. Something to consider is to reach out to your provider before your next visit or if it’s a new doctor, when scheduling the appointment and let them know you’d strongly prefer it if they could tell your partner they have to speak with you alone.

Many doctors are starting to screen for domestic and intimate partner abuse during their initial intake with patients. If you are in an abusive or toxic relationship, know that being upfront with a medical professional is best so they can help you with options. They will be able to provide you with information on local resources as well as document what you are going through. You might even ask your doctor if you can use the privacy of the exam room for to call your local domestic violence agency, like Turning Point of Lehigh Valley, since you may not be able to make the call from home.

Privacy of your health information is important. One way you can protect your health information is to talk with your doctor or staff privately and ask to password-protect your chart/medical information as well as update your HIPPA form to reflect the people whom you approve to be able to get your information. Under HIPPA, you have the right to keep your medical information private. This way nothing about your medical history or appointments will be discussed over the phone unless the person calling can provide the correct password. The word you choose should be something easy for you to remember, but not something your partner would guess.

We strongly encourage you communicate certain things to your doctor about any abuse that may have occurred. Did you know that if your partner has strangled, attempted to choke you, hit you in the head, or cause you to lose consciousness could lead to a medical diagnosis such as traumatic brain injury (TBI). This can be very serious and unfortunately is all too common. Abuse comes in many forms and it escalates and intensifies over time.

It is also very important to tell your doctor if you are pregnant as well as if you are concerned about your partner trying to get you pregnant against your will. We know that abusers have the ability to control reproductive choices in their relationship, whether it is not using a condom or tampering with birth control. You may want to consider asking for a birth control method in which your abuser does not know you are using. You can talk to your health care provider about different forms of birth control that may be harder for your partner to interfere with. They may also be able to speak with you about emergency contraception that you could keep somewhere secret in case you have been forced to have unprotected sex. If you do not feel comfortable having conversations about your sexual health with your current doctor or OBGYN, you can always call your local Planned Parenthood.

We understand that it takes a lot of courage to speak up and share that your partner is hurting you in your relationship, whether that is emotionally, verbally, physically, or sexually. It is very important to practice self-care so that you have the strength to get through an abusive relationship. You deserve to be safe and happy in a healthy relationship based on trust, honesty, communication, respect, and equality. Speaking up and telling your doctor can be your first step towards getting the safety and protection you deserve.

If you are interested in speaking with an advocate specifically for survivors of intimate partner abuse, our advocates are available on our 24/7 Helpline – (610) 437-3369. Everything is at no cost and is confidential. You can also visit our website for more information at www.turningpointlv.org.+

“Should I Stay or Should I Go?”

By DONNA BAVER ROVITO



“How are you protecting your family from COVID-19?”

Families throughout the world have asked that very question – but none more urgently than the families of physicians on the front lines of the pandemic. Those taking care of the sickest patients put not only themselves, as dozens of physician deaths around the world tragically attest, but their families at risk for exposure. As a result, many physician families have resorted to extreme measures to keep themselves and their children safe, ranging from deep cleaning to complete separation.

One physician’s husband, a retired PhD who ran a physician wellness program at a major health system, asked what physician families are doing to protect each other in one of the many Facebook groups dedicated to physician families, Physician Family Community:

“My wife is a family physician on the ‘front lines’ of this epidemic. We are trying to figure out whether and how much to separate over the next few weeks. Our children are grown and we are in our mid-60s.

We have instituted a few rituals, all as experiments so far:

1. A laundry basket on the porch that she puts all her clothes into when she gets home and then takes a shower;
2. We sleep in separate bedrooms;
3. We eat at the big dinner table - far apart like rich people in those British TV shows;
4. We fix our own breakfast, and I fix dinner for both of us;
5. I’m totally isolating from others to reduce likelihood that I will make her sick.

Most family medicine couples/families I know are struggling with this issue of separation, like that song by The Clash: ‘Should I Stay or Should I Go?’ Not sure if we are distancing from each other too much or too little. Any tips?”
~Warren

The response from other physician families was immediate and detailed. Names have been changed to protect privacy. Many have developed detailed cleaning routines but haven’t separated:

“My husband works ER. He changes his clothes to hospital scrubs when he gets to work. He has his own room at the hospital to store the clothes he wore to work. He wears what protective equipment they have, which is on short supply. When he’s done with his shift he leaves his hospital scrubs for them to sanitize with their other laundry, showers, changes back to his clothes for the drive home. Leaves his work shoes by his vehicle in the garage. He showers before seeing any of us. Washes the clothes he wore to/from work on sanitize cycle. Wipes down bathroom/sink area he used. A hug when he leaves for work but no kiss. We leave the house for walks and necessities only. Grocery pickup when we need groceries.” ~Kathy

“It’s recommended to frequently disinfect common touch areas in the home. Teach yourself to not touch your face; it took me about three days...It’s taking longer to teach my kids, but we are working on it. Always wash your hands before eating, or really touching anything in the kitchen.” ~Joseph

“I Lysol his shoes, his car interior, the doorknobs, put scrubs in the wash and then I Lysol the washer and wash my hands to my elbows. He is also going to the guest room at first known exposure. He will begin to shower in there as well. We don’t want to be separated and are doing the best we can to keep every surface clean and to wipe everything down. We knew EM would be ‘signing up’ for any and everything. It’s a stressful time.” ~Melanie

“She talked about taking some steps like sleeping in a different room. But she’s going through enough at work, I’m not allowing any stress here at home. My aim is to keep everything as normal as possible and try to give her a chance to not think about the virus as often as possible.” ~Jack

Numerous families reluctantly isolated the physician in a variety of ways:

“My husband is self-isolating in our basement. Even close friends didn’t understand the scope of it until I showed them pictures of my husband playing tic tac toe with my kids on the window with dry erase markers and doing bedtime songs with a wireless speaker so they can still do some of our bedtime routine.” ~Becky

“We temporarily relocated. I’m 30 weeks pregnant with a 2-year old. OB recommendation.” ~Allie

“I know a family where the physician spouse is staying in a camper in the driveway. His wife and children are keeping their distance from inside the house.” ~Jimmy

“I moved to the basement bedroom. My grown daughter lives upstairs and he is quarantined to the master suite and gets meals prepared and delivered there. He gets to eat all of the stinky garlicky foods he doesn’t normally eat because it is wife repellant. I cook for him and make smoothies to keep in his yeti cooler and check on him regularly to see if he has what he needs. I put fresh sheets on his bed every time he goes to work. He also goes for a walk every day. I make sure he feels like he is on vacation the best I can. We socialize in the yard in chairs at least 10 feet apart. We miss each other. But this is only a period of weeks or a couple of months; we should ride this out and stay as healthy individually as we can.” ~Kathleen

The physician’s husband who started the discussion noted: “I’m afraid this is going to be a very difficult period over the next couple of months. But I’ve also noticed that doctors and nurses feel called to help in these situations, and perhaps ‘thrive’ is too strong a word, but they do perform very well in a crisis!”

Indeed they do. And for ALL they do, our grateful nation can’t thank our physicians – and their families – enough!

Stay #PhysicianFamilyStrong+

Donna Baver Rovito is the editor of Physician Family Media, a division of the AMA Alliance, which comprises a quarterly magazine, website, blog and robust social media presence to support physicians and their families. She is married to local surgeon Peter F. Rovito, MD. They have two children: Peter, who will begin medical school at PCOM in the fall, and Tony, who recently obtained a Master’s in criminal justice and hopes to become a federal agent.





INGENUITY: The Word and Work of the Moment

From day one, St. Luke’s recognized that Coronavirus and COVID-19 would cause a great deal of anxiety and fear in both the general public and here among our St. Luke’s family. We knew that the community would need our commitment to continue to provide the highest level of care for them during the COVID-19 pandemic.

We established constant open lines of communication with the CDC and our state and local health departments for the latest information and activated our emergency plan. We tried to manage public fears and avoid overwhelming testing capacity. We stressed to people to stay home and call their doctors. We offered a hotline as a direct and immediate way to respond to an overly anxious public. We directed people to testing sites AFTER they called their doctors and/or used the hotline.

The bottom line is, we were prepared. But we also used the crisis to do what we do best. Coronavirus / COVID-19 provided St. Luke’s with an opportunity to innovate, invent and improvise. Ingenuity became the word and work of the moment. Some of St. Luke’s most ingenious “hacks” to combat the COVID-19 pandemic include:

Versatility, Convenience and Strength of Microsoft Power

St. Luke’s harnessed the versatility and might of the Microsoft Power platform to track and control PPE, as well as using it for telemedicine, command center and many other applications and strategies to support the need for fast applications and access to data and information. Since we couldn’t have people sitting in a room face-to-face, Microsoft Power allowed us to manage PPE use virtually while we maintained social distancing.

Shortly after the virus became a major contagious health threat, Microsoft Teams was launched across the entire St. Luke's Physician Group. More than 1,900 physicians, advanced practitioners, office staff and administrators were trained for virtual visits with patients in just three days. The telehealth function of Microsoft Teams has facilitated personal and safe interactions between doctors and patients in the hospital using digital tablets. This "virtual rounding" reduces provider and staff exposure to the virus, limits unneeded use of protective personal equipment and allows family members to 'visit' hospitalized loved ones without risking contamination.

Convalescent Plasma Therapy

Convalescent Plasma Therapy

As the medical industry searches to find an effective treatment and develop a vaccine for the COVID-19 virus, St. Luke's has continued to participate in an innovative national research study on using convalescent plasma therapy as a possible lifesaving solution. Results of this blood plasma trial will help advance the medical community's understanding of how best to treat COVID-19 patients.

A Solution to Lab Transport Medium Shortages

St. Luke's lab staff found a solution to an anticipated "drying up" of the universal transport medium (UTM) supply: replacing it with a simple saline mixture to preserve test samples. Once saline was validated for this use, the salt solution became the go-to option in all outpatient COVID testing, which totaled some 1,500 tests weekly. Not only is this more convenient, easy to produce in-house and plentiful, it also saves the network about one-third of the cost of the UTM, \$1.04 per test for saline vs \$1.53 using UTM. And, this solution can be easily adapted for other oral swab tests like the flu. So, next year, these cost savings can be further increased.

Purifying Air for Patient Rooms

Ensuring that the air entering hospital patient care units is clear of airborne pathogens was more critical than ever during the deadly COVID virus pandemic, as it easily travels through the air. To expand the sterile, "safe zone" for med-surg patients recuperating at St. Luke's Allentown campus, a second in-duct air purifying unit was installed that, like the first, completely killed the virus in the air in 16 additional rooms, many occupied by patients with weakened immune systems.

Solving Saccharin Shortage Spells Sweet Success

As the surge of COVID patients started flooding St. Luke's hospitals in late March, not only did N95 masks and other PPE fall into short supply, so did the commercially sold saccharin testing solution used to ensure the safe and snug seal of the masks on the wearer. Special safety measures are taken to check that no germs can pass through or around the masks and enter the mouth or nostrils. Pharmacy, and Infection Control & Prevention, found a sweet way to concoct their own saccharin mixture. They opened and emptied 23 pink Sweet 'N Low sugar substitute packets obtained from the cafeteria into a 100 ML bottle, added water and stirred. The resulting mixture solved the shortage with a simple solution. While a bottle of common, commercial saccharin solution costs the network \$20, the price of the work-around was a mere 50 cents.

Zapping Bio Bugs Bigtime

St. Luke's "Bug Zapper" is a home-made disinfection unit for protective face masks with a name that might sound like it fries insects. In fact, its purpose is to kill biological bugs, specifically the corona virus. As the use of N95 and KN95 masks soared early this spring, and supply fell, St. Luke's responded with an opportunity to innovate, create and save money. The Bug Zapper helped us reuse these special mouth and nose coverings, rather than replace them, by disinfecting hundreds each day at a fraction of the cost of replacement. St. Luke's team members worked with the engineering expertise of Lehigh University to develop and seek patents for this economical and practical design, a five-foot high, octagonal, metal grid holding up to 200 masks, to be bathed with a revolving ultraviolet (UV) light for just 10 minutes.

And, finally, with this economical solution in hand, St. Luke's has been disinfecting masks for area first responders, and staffs at nursing homes, dental offices and endoscopy centers throughout the community. +

How Top-Performing Practices Will Grow and Acquire New Patients in 2020

By RICK CANCELLIERE

Your waiting room is no longer just outside your office. It's online, busy, and demands your attention. Given the volume of in-person interactions medical staff have with patients each day, it's easy to understand why practices don't give their online presence the same careful attention they give to monitoring what happens in the office or on the phone.

Here's the problem: your patients are digital consumers. They have moved to the Internet in droves, taking important parts of their medical care online – whether or not their doctor knows about it.

According to a 2013 Pew Research Center survey, four out of five respondents reported using the Internet to make a healthcare-related decision. In 2018, Inc.com reported that three in five survey respondents stated they would choose one provider over another because of a strong online presence. Today, in 2020, every doctor needs to ask: how does my practice fit into the digital world?

To grow and stay competitive, practices must offer the simplicity and convenience digital consumers expect to win patients. If you can order groceries online and have them delivered in two hours, why would you wait days or even weeks to hear back from the doctor? And who would order a new appliance, select a school or daycare for their child, or pick a car service center without checking online reviews?

You as a physician or practice manager must take action now to help your practice thrive in 2020 – and you start by following the example of fast growing practices. These five action steps highlight exactly how others are using digital technology to better reach and serve patients:

1. Practices Are Taking A 360-Degree Approach To Their Online Presence

You need to take control of your web presence. If you are like most physicians that read this, you immediately thought, “Well I have a website.” But that's simply not enough anymore. Today's patients read reviews and consume social media profiles. Today's search engines use every piece of digital feedback they can find to judge your practice.

Fast growing practices in 2020 understand this and now use a 360-degree approach to managing their web presence. They know their website isn't enough. Relevant, accurate, and compelling information laid out across the entire world wide web, spanning the entire patient journey for both robots and patients to consume, is the true core to a strong online presence that appeals to prospective and current patients alike.

2. Practices Are Done With “Online Brochure” Websites

It's not enough to “set out” a website that sits on the Internet, waiting for people to find it. Websites need to cater to the two key groups that consume them: mobile patients and search engines.


Patients today “live” online and constantly use the Internet to meet their needs promptly. Now nearly two-thirds of Americans are smartphone owners, and more than 70% of healthcare traffic is mobile as a result.

At the same time, search engines like Google deliver results to patients with a sophisticated, evolving algorithm. Search engines aim to find the best information in the best format – a format that's mobile-friendly and well structured.

This is where 80% of independent practices fail. Sites developed to be little more than an online brochure will become outdated just as fast as the magazine in the waiting room.

You might be the biggest practice with the best off-line reputation and the highest number of specialists doing the most difficult cases.

But online, you're on page 2 – beneath a long list of practices that don't deserve the positioning. They have been rewarded where you have been penalized.



The solution? In 2020, your website needs to make these two groups happy with a structured, modern rebuild. This is what will guarantee that patients will find and come to your website.

3. Practices Are Providing Answers Before Every Appointment

Once you have an upgraded website... well, your patients still need a little more from you. Patients today aren't just looking for phone numbers and taglines. They go online to look up information about specific health problems, treatments, and care options. In fact, search engines are the first stop for 8 out of 10 people seeking health information.

In 2020, you need to accept this behavior and patient need, and address it head-on. That means your practice needs to focus on beating your competition not just with a better website, but a useful website – a website focused on your specialty, your treatments, and the real-life ways you make your patients' lives better.

4. Practices Are No Longer Forcing Patients To Call Them

Do you expect patients to pick up the phone for their every need? If you said yes, you should also expect patients to give your practice a hard pass. 77% of patients say that the ability to request, book, change, or cancel appointments online is important in their choice of a healthcare provider.

In 2020, you need to move past this traditional method of contact. The reality is that asking your patients to connect during business hours is a huge inconvenience for a time-strapped consumer. And not only will online appointment options make patients happier; but they'll help office staff to work more efficiently.

5. Practices Are Taking Online Reviews Seriously

Do you take your reputation seriously? Because your patients do. Digital marketing leaders have found that nearly three-quarters of patients use online reviews as the first step when finding a new doctor.

In a day and age where 84% of consumers trust reviews as much as personal recommendations, your reputation needs to be a priority. In 2020, it's your responsibility to curate and engage with your online reviews and reputation. If you don't, your patients will notice – and it will influence their future care decisions.

We hear you asking: How can you possibly address your presence, website, content, mobile services, and reputation?

impossible for individual doctors to be there with them. PracticeBeat addresses each of 2020's leading patient acquisition factors with an all-encompassing solution focused on the patient journey that understands the big picture and strategy needed to successfully please and connect with patients online.

PracticeBeat.com helps medical practices outrank competitors, leap ahead as market leaders, and drastically increase market share and new appointments in 30 days. Patient leakage is very expensive – but we manage the full patient journey while solving very technical problems like visitor loss, inconsistencies, and structured data.

For a free patient barrier evaluation of your medical practice, please call us at 412-328-2150 or email at rick@practicebeat.com. +

Rick Cancelliere is the Founder and CEO of Treatspace.com and PracticeBeat.com. He is a nationally recognized entrepreneur with expertise in healthcare technology.

Patients may be online - but it's nearly

To All Our
Healthcare Workers,
Essential Employees
And First Responders

Thank You



Hoffmann

Publishing Group

Hoffpubs.com

