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Managing Your Urology Practice through the COVID-19 Pandemic

Host: The health care community around the globe is on the front line of fighting the COVID-19 pandemic. Studies have shown that providers may be at an increased risk for infection. On today's episode of "The Inside Tract," we're exploring what medical practices need to know about this increased risk and how to handle it if someone in your office tests positive for COVID-19.

Today, we are joined by Dr. Jonathan Rubenstein, a urologist with Chesapeake Urology in Maryland. Dr. Rubenstein is also the chair of the AUA's Coding and Reimbursement Committee. How do you balance the business piece of this crisis with the fact that your staff are the very people working to help fight COVID-19?

Dr. Rubenstein: So, certainly it is a challenge, and this is a challenge unlike anything that we've seen before. Not only do we have our doctors and nurses, but we have a huge staff, and not only rely on us for their own income because these are their jobs and these are their livelihoods, but you know, this is a business that runs. And you know, the patients are what we take care of, the patients are also the business aspect of the business. And so, not only trying to balance the doctors and nurses or medical assistants, the staff that work in the office and the staff that work behind the office are all impacted by this. So, on one hand, we have patients that we need to take care of. There are patients with both emergent medical needs, urgent medical needs, and non-emergent medical needs. The challenge is trying to make sure we have the right amount of staff, not only that we're serving our patients in the hospital setting, in our surgery areas, but also in our offices, but that we're not overdoing our staff and overdoing the number of doctors that we have.

So, it's been a tricky balance and we're probably gonna need to change it week to week. Unfortunately, a lot of businesses have to lay off employees or furlough employees just because of a lack of business. But at the same time, we have to be available to serve our hospitals, to serve the patients in the hospitals and serve the patients that need to come in to be seen both for emergent and semi-emergent visits, both in our office and our surgery centers. One of the biggest challenges have been the moratorium in a number of states that has not allowed non-emergent or these elective procedures to be performed in a hospital, an office, or an ambulatory surgical setting. So again, having the right number of staff and the right number of doctors has been a challenge.

We also don't want to overexpose our patients and overexpose any employee to the possibility of getting Coronavirus. We don't know of any patient that walks in the door, no matter what age, no matter what health condition they have, on whether or not they're affected and asymptomatic. Us as health care providers not only need to be able to serve patients, we also have to protect our patients for unnecessary exposure and us passing potentially Coronavirus onto a patient who comes in the health care setting. So, certainly, this is a challenge unlike one we have seen in our business, in the history of our business or the history of any small practice, and one we hope to not have to ever face again.

Host: And we're learning that the doctor-as-a-patient scenario is becoming far more likely than perhaps originally anticipated. And given the infectious nature of COVID-19 even in asymptomatic patients, what should practices be doing to prepare for this doctor-as-a-patient scenario?

Dr. Rubenstein: So, one of the biggest challenges is trying to run a business and take good care of patients while not exposing ourselves, the other members of our practice or even patients unnecessarily to the possibility of getting Coronavirus, which can happen both in an office setting or a hospital setting. So, again, trying to find this balance of limiting foot traffic in our offices. Heck, we had even considered closing down our offices altogether, but we can't do that because we do have emergent patients that we need to see and urgent patients that we need to see. We had started weeks ago by limiting foot traffic into our office, giving patients some warnings about travel bans, traveling from certain countries, certain symptoms. We wouldn't even let them in our office to begin with. Over time and as this has all evolved, we've realized that even patients who are asymptomatic could be carriers but we just have to do our best to balance it.

We certainly do not want anybody in our office who has recently come from a hotbed or a high-risk area and we do not allow any patients in our office who can exhibit any signs of Coronavirus at all. We have obviously already been advocates for handwashing, hygiene, cleanliness, cleaning our hands and using alcohol on our hands, you know, between patients. We've become even more vigilant now. We wipe down our surfaces a lot more than we've wiped down in the past and just really following the CDC guidelines about how to maintain our practice and maintain cleanliness, yet at the same time, we are serving patients. We do know that every day we are potentially exposing ourselves, our nurses, our medical assistants and our staff to patients with Coronavirus. And therefore, you know, day to day, we're changing our practice based upon updated CDC guidelines and updated understanding of how this disease could be spreading.

Host: What happens if a member of the practices' staff or a provider test positive for Coronavirus? What protocols should practices be following right now in terms of reporting it to the authorities and things along those lines?

Dr. Rubenstein: All health care providers really it's their duty to report a positive test to the State Health Department. And typically, when health care providers are being screened anyways, the State Health Department is going to at least be somewhat involved. Patients who are [inaudible 00:05:54] certain risks, will already have been in contact with the State Health Department. Each state will have their own guidelines on how to proceed. Certainly, obviously, we want the care of the provider needs to be in the forefront, it means we need to make sure that they are taken care of. Obviously, we then need to follow the CDC and best practice guidelines for whether or not they're going to be recovering from home or whether they need to be hospitalized based upon the severity of their symptoms, which is no different than any anybody who comes down with a Coronavirus and is potentially symptomatic. Certainly, they would be quarantined for a certain period of time or at least at their home. Typically, it's been around 14 days and I believe that's sort of a national standard right now. Although it does vary state to state.

So, obviously, the state would become involved with any health care provider who does test positive. We would then figure out not only from the state, but from our own internal policies about which patients might need to be contacted, who may have been exposed to this provider and what other health care providers within our office and other members of our staff who also may have been exposed during that time and follow the same guidelines for evaluating them, testing them, and having them treated if they become positive.

Host: Dr. Rubenstein, what are the current CDC guidelines for a health care provider that has come into contact with a COVID-19 positive patient?

Dr. Rubenstein: So, the CDC has a lot of information on their website and they also have an emergency phone number to call if there's any questions about it. And that phone number is 770-488-7100. And while the guidelines may change day to day and week to week, currently the recommendations for any health care provider is to monitor themselves for symptoms, such as, you know, taking their temperature and knowing and having a plan on who to contact if there's any symptoms such as a cough, respiratory issues or even a sore throat.

So, the CDC has sort of broken things down to active monitoring, self-monitoring, and self-monitoring with a delegation supervisor. Self-monitoring is just looking and checking out yourself, sort of I described. Active monitoring is when the state or local health authority has taken responsibility for being in

contact with you and helping you along. Self-monitoring with delegation supervisor is you help not only checking yourself but you're in close contact either with your institution or potentially the state. Close contact is really defined as being within six feet for a period of time where you might acquire Coronavirus.

And really, how it's been broken down is to whether or not the patient has had any protective, such as a face mask, protective gear on themselves and therefore, that helps determine your own individual exposure. So, for example, you come into contact with a patient who's Coronavirus or COVID positive who has a face mask and therefore is reducing their respiratory droplets, and the health care provider themselves has no personal protective equipment on, they're considered high-risk. So, they need to be actively monitored and they really should not work for 14 days. They need to reduce their exposure to anybody else. If your health care provider who comes at risk with a patient who has a face mask and health care provider themselves does not have a face mask, they're considered medium risk. But again, this should be active monitoring, no working. Health care provider and the patient has a face mask, health care provider does not have eye protection, does not have counter gloves, but does have face mask on is considered low-risk and should self-monitor or self-monitor along with their institution.

If the patient has no face mask and ends up being COVID positive or Coronavirus positive, that again increases the health care provider's risk. And again, whether or not they have no protective equipment or no mask or no eye protection on, again, those health care providers are considered high-risk. They undergo active monitoring along with their state or local health care authority and really should not be working or expose themselves to anyone else for 14 days. Again, if it's just no gloves or gown, they're considered low-risk and can self-monitor.

So, it's really important to understand if you've been in contact with somebody with Coronavirus, if they've had a face mask and are reducing their shedding by having a face mask on and your individual level of personal protective equipment that's been on to help determine your next steps. But once again, please look for this on the CDC website for the details and also for updates and changes.

Host: Dr. Rubenstein, we know that so many things are changing with the Coronavirus on maybe a daily and even hourly level. Do you anticipate this being another one of those items that changes, the CDC recommendations for coming into contact with a COVID-19 patient?

Dr. Rubenstein: So, it's just is my personal opinion, not as an infectious disease expert myself, but this seems to change almost daily, our understanding of the disease, understanding the transmission, understanding the exposure. As all the experts work through their better understanding of this, they're going to make different recommendations that can help mitigate our own exposure, exposure to our patients, and exposure to the population here in the United States. And so, yes, I do believe that not only the CDC is going to continuously be updating and changing their recommendations, but individual institutions will also keep changing. I think it's really important that all health care providers understand the CDC guidelines and continue to keep themselves abreast of any changes that could go on at any time. You just never know when something updates, something changes, somebody has discovered something, and this virus, you know, could have mutated compared to how it was in a different country. Therefore, it's really important that we understand how things are going on here in the United States for our own health and health for our patients and our populations here.

Host: Dr. Rubenstein, if there's anything else you want to tell us about what your practice has done in response to the COVID-19 threat or any other ways you're helping staff and patients stay safe, please just give us any final takeaways at this time.

Dr. Rubenstein: So, certainly, you know, like ourselves had already been involved somewhat in telemedicine, but obviously that ramped up significantly, not only because of the urgency of needing to move patients to telemedicine, but also a change in the rules of most of the insurance companies and also Medicare to allow pretty quick expansion of telemedicine and other telehealth services due to the Coronavirus outbreak. Certainly, we have tried to limit any foot traffic in any of our offices or procedure rooms at all possible. We have canceled all elective cases. We will only be performing urgent and emergent procedures both in our setting and hospital settings.

Again, the more that we can reduce patient-to-patient interaction, patient-to-patient crossover, patient-to-provider crossover, the better it is for the health of our patients, our community, and our practice. And it's just the right thing to do. We encourage all of our patients to go to telemedicine and we will only bring a patient into the office, if it is an emergent nature and the patient needs a physical examination. Otherwise, all patients should be handled through a telemedicine visit.

Host: Dr. Jonathan Rubenstein is a urologist with Chesapeake Urology in Maryland, he is also the chair of the AUA's Coding and Reimbursement Committee. Thank you, Dr. Rubenstein, for joining us on today's podcast.

Dr. Rubenstein: Thank you so much.