Primary Care Asthma Program Newsletter

https://hcp.lunghealth.ca/clinical-programs/

PCAP Resumption of Spirometry Recommendations

We understand that resuming spirometry has been a difficult process with new evidence and recommendations emerging every single day regarding SARS-COV-2 (COVID-19) and the case counts changing in various regions. Taking into consideration the guidelines, recommendations and position statements available from the Canadian Thoracic Society (CTS), European Respiratory Care Society (ERS) and Public Health Ontario, the Lung Health Foundation, with its PCAP partners, sought to develop a list of recommendations for resumption of spirometry in primary care including the recommendations for nebulized treatment in the community. Below is our recommendations. These recommendations are based on the best available evidence to date. These recommendations are subject to change as new evidence emerges.

Recommendations for Conducting Spirometry Testing and Nebulized Treatment in the Primary Care Setting during the COVID-19 Pandemic

The Lung Health Foundation remains dedicated to helping all Canadians breathe, and appreciates the long-standing partnership that exists with the Ontario Ministry of Health (MOH) in delivering an integrated model of care for asthma and COPD patients in Ontario. The Primary Care Asthma Program (PCAP) is an evidence-based asthma and COPD program intended to provide primary care providers with decision aids to support best practice regarding asthma and COPD assessment, diagnosis and management. Its development, implementation and evaluation are funded through Ontario's Ministry of Health, as one of the initiatives of the Ontario Asthma and COPD Program. We have, and will continue to help Ontarians effectively manage their asthma and COPD through the delivery of services and programs.

The Lung Health Foundation, together with its Primary Care Asthma Program (PCAP), is dedicated to supporting safe, evidence-based respiratory practices in primary care across Canada. With the emergence of COVID-19 (SARS CoV-2), a novel infectious respiratory disease, there has been a growing need for guidance on respiratory practices required to manage asthma, COPD and other chronic lung diseases. Here we provide comments on, and recommendations for the provision of spirometry testing and nebulized treatments in Ontario. In both cases, as for most issues relating to COVID-19, specific evidence is sparse and emerging rapidly. We have therefore drawn on limited relevant research, recommendations from experts and experience in other jurisdictions, pre-

existing evidence regarding similar respiratory viruses, and general precautionary principles available as of the date of these recommendations.

Spirometry Testing

The ability to carry out spirometry, a key diagnostic test for asthma and COPD, has been halted across Ontario because of the concern around COVID-19 transmission and risk to health providers performing these tests. Spirometry is an essential objective test that is used together with history and physical assessment to diagnose COPD and asthma, determine therapeutic response, and also to assess preoperative risk. The Ministry has amended Directive #2 for Health Care Providers to allow resumption of deferred services. Given the importance of spirometry testing, and recognizing, in particular, that asymptomatic individuals can be infectious, the provision of guidelines for the safe resumption of spirometry is imperative.
To date, we know that transmission of COVID-19 may occur following contact with infected droplets, including exposure to a cough or sneeze[1]. An April 10, 2020, Public Health Ontario (PHO) document on coughs states that, while a cough or a sneeze may generate aerosols, procedures that may cause a cough or a sneeze are not classified as aerosol generating medical procedure (AGMPs)[2]. Rather, an AGMP is a medical procedure in which the aerosols generated enable airborne transmission of the infectious agent[2]. For AGMPs, N95 respirators and eye protection are required. Currently spirometry testing is not listed as an AGMP. However, spirometry frequently induces *forceful* coughing, which may create conditions for aerosol generation.[3] This potential for aerosol generation, combined with the prolonged and close physical contact required to conduct spirometry, may increase the potential for COVID-19 transmission to the health care provider. Therefore, there remains an important question regarding what level of personal protective equipment (PPE) the health care provider should be wearing when carrying out spirometry testing in order to minimize transmission risk. Also whether considerations need to be given to air filtration and/or time between patients.

The Canadian Thoracic Society (CTS) and the Canadian Society of Respiratory Therapists (CSRT) has released a joint statement on July 12, 2020. In it, they acknowledge that some PFTs are more likely to induce cough than others and out of an abundance of caution, all PFTs should be treated as an AGMP and precautions be taken accordingly[4]. The American Thoracic Society (ATS) has also published a statement on AGMPs where they state that COVID-19 may be transmitted by contact, droplet and aerosol[5]. Currently there is no objective evidence confirming that COVID-19 is transmitted by aerosol. Until there is evidence that COVID-19 is transmitted by aerosol or spirometry is considered an AGMP, the Lung Health Foundation and PCAP recommends the use of eye protection, gloves, isolation gown and surgical masks with spirometry testing. Although this guidance document supports most of the recommendations of CTS, ATS and ERS, it disagrees with the assumption that coughing during spirometry testing should be considered equivalent to an AGMP. This is based on the current recommendations widely adopted regarding the precautions in managing COVID-19 positive patients in hospital wards and Emergency Departments. In these settings, known COVID-19 positive patients who are actively coughing are being managed as per droplet precautions. Health care providers managing these patients have not been infected at a higher rate as would have been expected if coughing was equivalent to an AGMP. Public Health Ontario released updated IPAC recommendations for use of personal protective equipment for care of individuals with suspect or confirmed COVID-19 on July 27 2020. Spirometry is not listed as an AGMP in these recommendations.

The CTS/CSRT and ERS documents align well with the recent Ministry of Health COVID-19 Operational Requirements: Health Sector Restart document released May 26, 2020 and updated June 15, 2020. They separate recommendations into a "Pandemic Phase" in which there is high community prevalence of COVID, and a "Post-peak phase" where there is low community prevalence. However, the recommendations are the same for both phases, and so we have provided a single list of recommendations. The key issue they considered was whether PPE use should change during a low prevalence phase. Without further evidence and ensuring safety of patients and staff, they (and we) recommend the continued use of full PPE (mask, gown, gloves, face shield or goggles) in

the post-peak phase. Local Public Health guidance will indicate when it is appropriate to move to the post pandemic phase. We provide their recommendations here, with some minor changes.

Spirometry Testing Recommendations:

- Implementation of a pre-screening process (assessing for low or high-risk patient and low or high-risk community) is required. This should occur within 72 hours of the scheduled test and upon entrance to the site on the day of testing.

- During high community prevalence, testing should be limited to urgent/essential tests only for immediate diagnostics of current illness (e.g., time-sensitive and critical for clinical decision-making such as suspected lung transplant rejection).

- For patients deemed a high-risk or from a high-risk community, testing should not be performed in the primary care setting.

- Delay testing on patients who are suspected to have or have tested positive for COVID-19 until after they are considered recovered as per provincial guidelines.

- Delay testing on patients who are suspected to have influenza or other upper respiratory tract infection until they have recovered.

- Ensure physical distancing in the waiting areas/patient seating areas (at least 2m). Staggered appointment times may be appropriate to limit the number of patients in waiting areas. This will depend on the number of other staff on site who are concurrently seeing patients. Staff work stations should also follow physical distancing rules. One-way patient flow should be implemented to minimize contact with individuals.

- History taking and communication of results and/or further counselling should take place in a room separate from that used for testing or performed remotely before the patient arrives and when the patient has left the facility respectively.

- Proper hand hygiene before and after testing for both the patient and the provider is required

- Patients should be tested in designated testing rooms

- Consider tubing/cable length to ensure physical distancing rules are followed (at least 2m between the patient and the healthcare provider).

- For bronchodilator responsiveness testing, patients should be encouraged to bring their own reliever inhaler (e.g., salbutamol) and spacing device. If the patient does not have a reliever inhaler or does not remember to bring their inhaler, the site should provide a new salbutamol MDI (one-time use) and a spacing device (one-time use) or follow their local public health guidelines on cleaning MDI and canisters between patients.

- Sufficient time should be allowed for testing and for cleaning/decontamination of all surfaces and test equipment between patients with an appropriate disinfectant, and for proper PPE donning and doffing. Time should also be taken to recalibrate lung function equipment after decontamination to maintain

accuracy of equipment. Overall, it is recommended that additional time be scheduled for each test to allow for the appropriate measures to be taken to ensure safety.

- Organizations advocating AGMP precautions suggest that if feasible, HEPA filtration systems with UV germinal lamps should be used in the room where testing occurs[6]. For most primary care sites, the cost of these systems is prohibitive. PHO and the Ontario Chief Medical Officer of Health (CMOH) position is that spirometry is not categorized as an AGMP. For PHO guidance on HEPA filtration and the adequate number of air exchanges for airborne conditions can be found here.

- Rooms should be ventilated post testing by opening doors and windows (if possible). Sites may decide to measure the air exchange rate in each room used for testing. Recommendations vary regarding how much time should elapse between test termination and subsequent testing, from 15 minutes to 3 hours. CTS recommends 3 hours where a room has less than 6 air exchanges per hour or the rate of air exchange is unknown. This reflects the assumption that coughing during spirometry is an AGMP. PHO and the Ontario CMOH position is that spirometry is not an AGMP and the CTS recommendations go above and beyond precautions that PHO and the CMOH would recommend for spirometry testing.

- Testing should be carried out with in-line bacterial/viral filters. Spirometers that do not have the capability of adding an in-line filter should not be used at this time.

- With regards to PPE, we are recommending that all staff should be wearing at minimum a surgical mask, gown, gloves and face shield or goggles. Evidence to this can be found in the PHO document on coughs.[2] The categorization of spirometry as an AGMP does not align with PHO and the Ontario CMOH position on this and therefore, taking droplet/contact precautions are appropriate. Organizations that have considered spirometry an AGMP have advocated for the use of N95 (fit tested) masks and may choose to implement these precautions

- Patients should also be provided with face/surgical masks or asked to bring their own face coverings, to be worn at each point when active testing is not being carried out.

- When planning to restart testing in your community, work with your local public health authority to determine prevalence in your area (low-risk or high-risk community). All staff should be trained regarding the approved comprehensive plan to prevent another infection outbreak.

Recommendations for Nebulized Inhaled Treatments

There is also a growing need in home and community care for guidelines on precautions that should be taken for patients on nebulized inhaled treatments (this document does not address in-hospital settings). Nebulized treatments are given for acute asthma or COPD exacerbations in long term care facilities and individual homes. It has been established that nebulization of medication may increase the risk of spreading COVID-19 through aerosolization[7]. Though PHO states there is inconclusive evidence documenting transmission via nebulized therapies[8] a risk assessment should be conducted with regards to the therapy being categorized as an AGMP. Regarding nebulized therapies inside a long term care facility and an individual home, we endorse the Canadian Thoracic Society (CTS) position statement from the Asthma Clinical Assembly that recommends nebulized therapies should be replaced by metered dose inhalers (MDI) or dry powder inhalers (DPI) to administer short acting bronchodilators and inhaled corticosteroids inside health care facilities (including nursing homes) to reduce the risk of aerosol spread of virus particles[9]. For home settings, we recommend the direction advocated by the CTS. It recommends that the nebulized treatment should be provided in a separate room, away from other family members[10]. For health care providers working in the community, full PPE should be worn (N95 mask, face shield, gown, gloves) when treating and providing care for a patient requiring nebulized inhaled treatment. The

Ontario Chief Medical Officer of Health regards the recommendation to use an N95 mask in the above circumstance as reasonable at this time.

These recommendations are based on the best available evidence to date. These recommendations are subject to change as new evidence emerges.

We thank everyone who assisted in developing and providing input to our recommendations including Dr. Karen Jones, Public Health and Preventive Medicine Specialist, Assistant Professor University of Toronto, Dr. Christopher J. Allen, Associate Clinical Professor McMaster University, Respirologist at Firestone Institute of Respiratory Health, Hamilton, Dr. Jane Batt, Respirologist and Scientist at St. Michael's Hospital, Toronto, Sara Han, RRT, CRE, PCAP Provincial Coordinator, Lung Health Foundation, Meridene Haynes, RCPT(P), CRE, Compass Health, Hamilton, Michelle Maynard, RRT, CRE, Somerset West CHC, Christina Dolgowicz, RRT, CRE, North Lanark CHC, Jessica Schooley, RN, CRE, Kingston General Hospital, and Madonna Ferrone, RRT, CRE, Best Care Program, Windsor.

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Is vaping cessation like smoking cessation?

By **Sherald Sanchez,** PhD Student, Institute of Medical Science, University of Toronto, Research Coordinator, Ontario Tobacco Research Unit, Centre for Addiction and Mental Health

What we know about vaping cessation among young people

In Canada, prevalence of vaping is highest among youth and young adults[1]. There is evidence suggesting that young people who vape daily feel some level of addiction to vaping[2–4] and that young people are now seeking help to stop vaping [3–6]. However; little is known about vaping cessation.

To bridge the gap between the current state of research on vaping and the urgent need for vaping cessation interventions; researchers, clinicians, and public health professionals have turned to the literature on smoking cessation under the assumption that vaping, and smoking are fairly similar. Unfortunately, there is limited evidence that existing tobacco cessation interventions for young people are effective in helping them stop smoking long-term[7]. Furthermore, vaping differs from smoking in many important ways which have implications for the design of interventions.

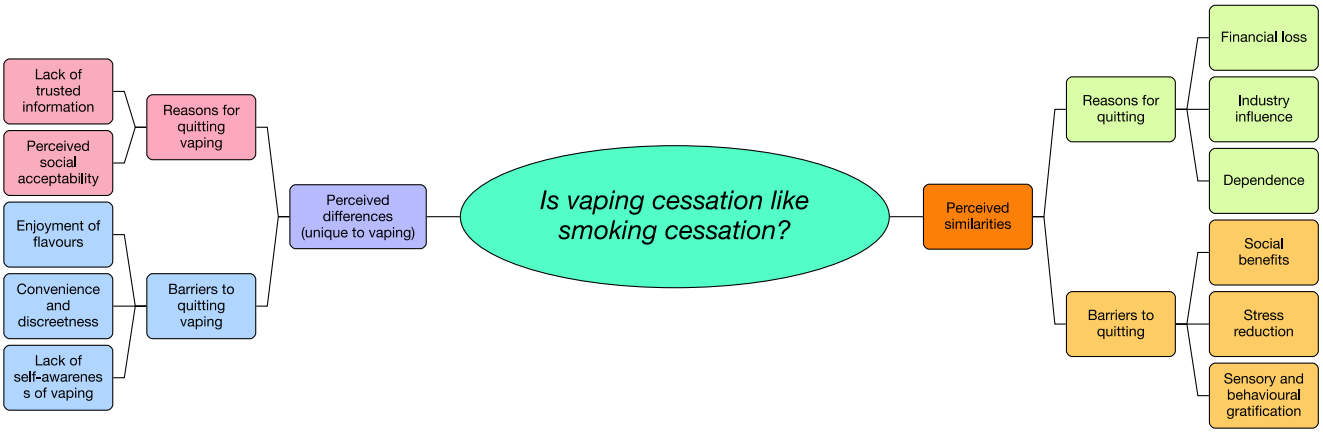
What this study adds

A recent study examined a series of focus groups attended by 14 youth (ages 16-18) and 27 young adults (ages 19-29) who wish to stop vaping. We sought to understand the nature and extent to which vaping is perceived to be different from smoking. Methods and analyses are reported in detail in a forthcoming manuscript[4]. This piece summarizes insights from young people who vape, focusing on key differences between vaping and smoking to help inform the development of vaping cessation interventions—see **Figure 2**: left-hand side.

The majority of participants reported vaping nicotine e-cigarettes daily in the past month and feeling "somewhat addicted" or "very addicted" to vaping. Among participants, pod- and salt-based nicotine e-cigarettes, like JUUL and Vype, were the most popular.

Figure 1. Common types of e-cigarette devices.

Figure 2. Mind map summarizing perceived differences and similarities between vaping and smoking relevant to cessation.



We identified perceived differences from participant narratives relating to reasons for quitting and barriers to quitting vaping.

Reasons for quitting unique to vaping

Three themes unique to vaping emerged relating to the barriers to quitting vaping: enjoyment of flavours, convenience and discreetness, and lack of self-awareness of vaping behaviours.

The majority of the participants cited enjoyment of flavours as the primary reason for sustained vaping. Additionally, convenience and discreetness of vaping were prominent themes in participant narratives. Vaping was described as “easy” and “very convenient,” and vaping “everywhere” and “first thing in the morning” while still in bed was a common narrative among the participants. Youth ages 16-18 shared similar experiences of vaping discreetly at school in their classrooms, bathrooms, and hallways. Youth participants provided detailed accounts of ways in which they were able to maneuver around the “No Vaping” policies in their schools. Some stated they would “just vape into the lockers and no one really like cares”. Others were more resourceful. For example:

“When they put in like the detectors at my school, people just brought like cups and then they started in class and like just with the straw would just put it into the cups… like you can just like inhale and then exhale through the straw into the cup and it just isn’t noticed.” [Youth, former smoker]

Participant responses suggest that the accessibility of vaping can be perceived as a double-edged sword; it was an advantage over smoking and at the same time, a disadvantage for those wanting to quit vaping. The ease of accessibility often resulted in a lack of self-awareness of vaping behaviours.

Several participants shared that they had little to no awareness of how much or what they were vaping and expressed concern over the implications of this lack of understanding.

“With a cigarette, there’s a cue, you’re done. Whereas I guess with vaping, it’s not as much, because yes, it lasts longer… they say, like one JUUL pod is the equivalent of one pack [of cigarettes]… that was quite petrifying because I’m like, ‘well I’m smoking [vaping] three pods a day, that’s not bad’. And then I’m like, ‘Oh, that’s three packs of cigarettes, great.’” [Young adult, former smoker]

Barriers to quitting unique to vaping

Lack of trusted information and perceived social acceptability were two themes that emerged as barriers to quitting in participant narratives specific to vaping, but not smoking.

Overall, among participants, there was a strong desire for clear information about vaping communicated by trustworthy sources. This includes sources such as university institutions and non-government organizations. For many participants, a lack of certainty with regard to the health effects of vaping led them to seek information through the Internet and anecdotes from friends and other members of their social circles.

“I would be much more likely to quit if there was a lot of evidence about like, how bad it is, like, it’s still too early to have that. So, if we had like, the amount of evidence you have for cigarettes for vaping, I would – I think I would probably quit.” [Young adult, former smoker]

Perceived social acceptability of vaping was a salient theme in participant responses. In contrast, many participants discussed the negative public perception associated with smoking. In particular, one former smoker identified “the smell, the visual” of smoking as key aspects that deterred him from smoking. He also added: “It's [smoking] really obvious. There's a public perception about it.” [Young adult, former smoker]

Notably, youth participants ages 16-18 held strong negative feelings towards smoking. They discussed the stigma against cigarettes as a key factor that prevented them from ever trying smoking. Youth ages 16-18 also provided insights into how environmental factors, such as advertising and availability of vapes at convenience stores had an impact on their views and behaviours.

“You see [vaping] billboards and, like, bus stops.” [Youth, never-smoker]

“I think environment is key, like if you have a convenience store near you that sells to you, underage or not, it’s going to be really easy to access them. And people around you who are more okay with that… Like I think environment is the number one thing.” [Youth, never-smoker]

So, is vaping cessation like smoking cessation?

While many issues surrounding vaping cessation and the mechanisms for behaviour change may be similar to smoking cessation, some issues are clearly distinct. Key differences included perceived social acceptability of vaping, levels of certainty with regard to the health effects of vaping, and levels of awareness of behaviours associated with vaping. Understanding these differences and the prevailing social context is critical to advancing vaping cessation research and practice among youth and young adults. Findings from the focus groups suggest that interventions specifically designed for vaping cessation may be more appropriate for this population compared to interventions that address vaping within the context of broader tobacco cessation frameworks.

Although there is significant overlap between vaping and smoking, understanding perceived differences in barriers to quitting and reasons for quitting is critical to advancing vaping cessation research and

practice among young people. Based on these findings, recommendations relevant to vaping cessation research and practice include:

- further research into understanding e-cigarette dependence and how it differs from traditional cigarettes
- development of vaping cessation interventions that highlight these differences and their implications for driving behaviour change
- deliberative engagement and collaboration with young people in designing relevant and appropriate interventions

About this project

Findings reported here are part of a larger study for *Designing Youth Vaping Cessation Interventions* led by Dr. Michael Chaiton and Dr. Robert Schwartz at the University of Toronto's Dalla Lana School of Public Health. This project is funded by the Substance Use and Addictions Program of Health Canada.

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Perspectives: A Look Inside How the Pandemic Has Changed Your Practice

Ellen Holmes RRT, RCPT(P), CRE, CCSH, North Lanark CHC

1. **What was the biggest challenge professionally during the pandemic:**

EH: My biggest challenge has been the inability to do a physical assessment and observe my patient's vital signs.
My second biggest challenge has been assessing patients who are going through the rehab program. The organization has purchased a PHIPPA compliant version of Zoom to do virtual sessions, but a lot of clients

are older and/or just don't have a computer or computer skills to attempt signing into the virtual programs. Team members are doing a lot of phone follow ups with these folks. We have a better plan going forward in the fall.

My third biggest challenge during the pandemic has been unstable internet service and having to learn new programs to offer extended access to our clients. I normally count on my boys to help me out with technological advances and they were both isolating in their homes.

2. What opportunity, if any, has arisen during the pandemic:

EH: My clients who have graduated the rehab program have been participating at home with online exercise videos provided by our program Physiotherapist. Many of them are doing the exercises regularly. Because they have been able to maintain their physical fitness and have been safely tucked into their homes there have been very few exacerbations. I can see this as a good option for folks who have already participated in the program and want to keep up the exercise. I have also noticed that their CAT scores are better since the pandemic.

3. How has your role changed during the pandemic and how might it change moving forward?

EH: My role as an educator hasn't really changed. I still carry out respiratory evaluations as well as one can over the telephone. I ask our Admin. Assistant to send out patient information sheets and Action Plans. Intake to the cardiopulmonary rehab program takes considerably longer as the questionnaires are lengthy. Asking our Admin. Assistant to send the forms out to the patients to complete has helped with the time management.

4. How has your relationship with your primary care colleagues changed during this time?

EH: I have found that reaching Physicians and getting a response has been much easier since the pandemic. We have been able to resolve patient care far more quickly than usual.

It has been different not seeing my colleagues in person. We do meet monthly by zoom which is always beneficial. I think we are communicating more now during the day. We are all using a platform called Jabber to bounce ideas and questions off each other.

5. What feedback have you received from your patients with the changes experienced in the delivery of care during the pandemic?

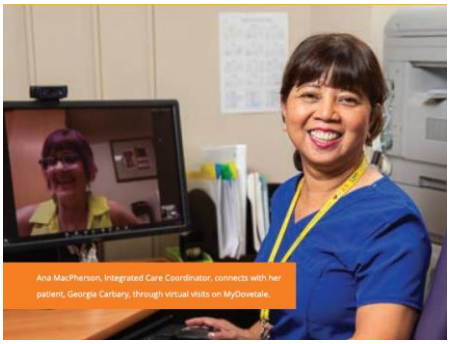
EH: The folks who were participating in the "in-person" rehab program are expressing that they can't wait until the centre opens again. It is clear that for folks who have participated in the 'in person' program want to continue in that way, however, hopefully with options for virtual, they will be keen to try that model as well.

Considering the heat and humidity this summer, my maintenance (Gentle Fit) folks were quite content to stay in their air conditioned homes and do their exercises at their own and on their time. They have even commented that this would be a great tool to keep them active during the winter months when snow storms prevent them from going out.

6. What is the number one lesson you have learned during the pandemic.

EH: "The proof is in the pudding." It has been refreshing to hear that so many of these folks are doing exceptionally well during this pandemic. The constant reminders in the past about hand washing, not touching their faces when they are out, using hand sanitizer when you can't wash your hands, asking the family to stay away if they have a chest infection, updated Action Plans etc., has paid off. This is very refreshing.

Ana MacPherson, MASc, RRT, CRE, CTE, Integrated Care Coordinator, Integrated Comprehensive Care Program, St. Joseph's Healthcare Hamilton



1. **What has been the biggest challenge you have faced in your role during the pandemic?**

   AM: The patient feeling isolated and anxious. But at the same time refusing an in-person visit.

2. **What opportunity, if any, has arisen during the pandemic?**

   AM: Virtual care via zoom or telephone, to keep connected with our patients.

3. **How has your role changed during COVID-19 and how might it change moving forward?**

   AM: Ensuring patients are coping – managing well with virtual supports from the whole health care team.

4. **What has been the biggest challenge you have faced in your role during the pandemic?**

   AM: The patient feeling isolated and anxious. But at the same time refusing an in-person visit.

5. **What opportunity, if any, has arisen during the pandemic?**

   AM: Virtual care via zoom or telephone, to keep connected with our patients.

6. **How has your role changed during COVID-19 and how might it change moving forward?**

   AM: Ensuring patients are coping – managing well with virtual supports from the whole health care team.

7. **How has your relationship changed with your primary care colleagues during this time?**

   AM: We noticed that the Primary Care Physicians have also been scheduling more phone call visits/appointments. We are coordinating care with the primary care providers, specialists and community providers during this time.

8. **What feedback have you received from your patients with changes experienced in the delivery of care during the pandemic?**

   AM: Most are appreciating the telephone/virtual visits to avoid infection. Some not so much. They are feeling isolated and anxious, and feeling vulnerable and detached from their primary care providers.

9. **What is the number one lesson you have learned during the pandemic so far?**

   AM: Follow up with high risk patients:

   i. Usually frequent flyers- and avoiding ED – they are maybe staying home – feeling ill but too afraid to come to ED for assistance

   ii. Anxiety/Depression/ feeling isolated – connect with them even for 5- 10 mins – know the emergency Mental Health numbers in your Area: for outpatient clinics/ 24 hour telephone services

   iii. Know which providers (primary care provider / specialist/ nurse practitioner / paramedics/ pharmacy) you have access to for assistance to help patients in their home

   iv. Have an Action Plan ready for an exacerbation more important now. Be prepared with your providers and patients.

Tony Kajnar, RRT-AA, RCPT(P), Senior Respiratory Therapist, Pulmonary Function Lab, Sault Area Hospital

1. What has been the biggest challenge you have faced in your role during the pandemic?

The daily uncertainty of our role, expectations and the looming spread of COVID were sources of our challenges. Many can appreciate the concerns of the unknown. The almost daily changes to organization as cases ramped up and new evidence was released created considerable uncertainty. Organizations were dealing with things differently, depending on their local community spread and have heard from others who were reassigned to totally different areas and duties.

2. What opportunity, if any, has arisen during the pandemic?

The pandemic provided an opportunity to review and develop practice recommendations with other stakeholders including the CRTO (College of Respiratory Therapists of Ontario), the Lung Health Foundation, RTSO (Respiratory Therapy Society of Ontario) and CSRT (Canadian Society of Respiratory Therapists). There were a number of conversations to review how we approached our practices which needed input from others.

This provided an opportunity to virtually meet and connect with others. Once we realized that operations could continue, we took the opportunity to complete long-overdue work, such as major software updates, while our referrals were limited.

3. How has your role changed during COVID-19 and how might it change moving forward?

The initial assumption was that we would be retrained and reassigned to different areas. This did not happen as planned and we were performing other duties in an effort to support acute care RT services. At this point the most drastic impact has been physical distancing and PPE. These are cumbersome and require significant time which impacts pre-existing operational inefficiencies. I am certain we are all getting tired of wearing these additional items and conducting additional screening. Many areas were not designed with physical distancing in mind, there are no easy solutions and everything requires more effort.

4. How has your relationship changed with your primary care colleagues during this time?

We reach out to our primary care colleagues for mutual patients. Everyone is concerned about the well-being of patients who may have had limited access to primary care during the initial shut down of elective services. The limited access to primary care is a concern. Virtual meetings have been more common, it is nice to be able to connect with them whenever possible.

5. What feedback have you received from your patients with changes experienced in the delivery of care during the pandemic?

Some patients are thankful to see enhanced PPE and precautions, especially those who require reverse precautions. Others have been concerned about attending appointments or less than pleased to have to wait longer for services or deal with the enhanced precautions. Many don't realize just how dependant they are on reading lips and have difficulty with communication with facemasks.

6. What is your number one lesson learned during the pandemic so far?

Keep focus on quality patient care. We all have a new car to drive but the “rules of the road” have not changed!

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