AMA experts discuss pandemic’s impact on rural America

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Featured topic and speakers

AMA Chief Experience Officer Todd Unger speaks with AMA Trustees orthopaedic surgeon Michael Suk, MD, JD, MPH, MBA, family medicine physician Gerald E. Harmon, MD, and infectious disease physician Megan Srinivas, MD, MPH, on updates regarding COVID-19 including the impact of COVID-19 in the rural communities of the United States.

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Transcript

Unger: Hello. This is the American Medical Association's COVID-19 update. Today we're discussing the impact of COVID-19 on rural America.

I'm joined today by Dr. Michael Suk, AMA trustee and orthopedic surgeon in Danville, Pennsylvania, Dr. Gerald Harmon, an AMA trustee and family medicine specialist in Georgetown, South Carolina, and Dr. Megan Srinivas an AMA section delegate and infectious disease physician in Fort Dodge, Iowa. I'm Todd Unger, AMA's chief experience officer in Chicago.

Dr. Suk, we hear a lot about the impact of this pandemic in urban areas like New York City, less so with rural areas. Tell us what you're seeing right now in your community.

Dr. Suk: First, thanks, Todd, for asking us to be part of this webinar. It's really great to be with you all. I'm an orthopedic surgeon that works in a large integrated health system here in Danville, Pennsylvania, called Geisinger. We have about 13 hospitals across the state and multiple states. We're obviously very concerned about the COVID crisis that's occurring in larger cities, but we haven't seen quite the same impact here in the rural areas. We're acting in many ways as if it's on our doorstep, but across about 10 of our hospitals right now, we have about 100 patients total, with the

highest concentrations being around 30 to 35, with about a third of them on ventilators in ICU. We've had some great successes of saves and a few deaths, but certainly not to the level of the surge that a lot of the cities are seeing at this point.

Unger: Dr. Harmon?

Dr. Harmon: My hospital system is a relatively much smaller system. We have a two-hospital system. I was in our local hospital system in the smaller of the two. We only had 30 total inpatients this past weekend, Easter weekend, and I was working a hospitalist and inpatient shift. I had two COVID positive patients among those 30 inpatients. One was on the ventilator. One was in the step-down unit. We've had, as you hear from Dr. Suk and other folks, a relatively limited impact, thank goodness, in small rural areas, but preparations are very intense.

Unger: And Dr. Srinivas, what are you seeing in Iowa?

Dr. Srinivas: So very similar to Dr. Suk and Dr. Harmon. We haven't yet had the peaks that we're seeing in the urban epicenters throughout the country. But because rural Iowa is a vulnerable population, having an older population, having a population with higher co-morbidities than the average urban population, this is definitely a community that's at risk. And we're starting to see the rise.

Just yesterday, we actually had our highest number of case positives within the state, and we're constantly seeing that trend being projected for the next two weeks to continue to rise. In fact, 29% of the tests that were done yesterday, or that were reported yesterday, came back positive in Iowa.

Unger: So it sounds like it's a certainly a quieter and waiting for this to happen. Although Dr. Srinivas, you recently authored an op ed piece in the Des Moines register that stated "rural America is not ready." How do you, and the three of you, feel about that proposition?

Dr. Srinivas: So I'm very concerned about what's going on because we see this projection where we're expected to peak, for instance, in Iowa in early May. But we're still having conversations about reopening the economy prior to us even hitting that peak, which is very disconcerting when we look at how this infection acts and the vulnerable populations we have in rural America that, because they have this false sense of security due to a smaller population density, are even more vulnerable if they're not practicing proper social distancing during this time.

Dr. Suk: Todd, I think that the interesting game that we're all playing right now, and it's not really a game for fun, but it's trying to put a lot of reliance on our predictive modeling that occurs. So in areas like rural central Pennsylvania, we have really different waves that we expect.

So, for example, in our hospitals and Scranton and Wilkes-Barre, which are much closer to New York City, we expect the wave to hit them sometime in early May.

Whereas about an hour away where I currently am in Danville, Pennsylvania, we don't expect the wave to hit us until possibly end of May, early June. So a two to three week cadence of kind of a series of waves that can occur across multiple hospital systems.

It gives us the advantage I think, of being able to allocate resources within our large network so that if one hospital gets overwhelmed, we can shift to a lesser capacity hospital, at this point, in order to help diffuse some of that surge capacity.

But again, I think our biggest challenge is putting a lot of faith in the predictive modeling that's out there. Everyone says it's coming, and we've been waiting for it to come. Everyone thinks that this is the day of the peak, but then tomorrow we get more numbers. And so it's a challenging situation for us.

Dr. Harmon: One of the things, Todd, that we see in a small hospital system like mine with two hospitals, we don't have a workforce depth. We just don't have a very deep bench.

If I got a wave, if we received a wave of COVID positive patients, I have two intensivists, two pulmonologist, that's it, scattered between two hospitals that are 30 minutes apart. So it's easy to overwhelm our limited resources. One of them was had a non-COVID illness for the first couple of weeks of our recent quarantine. And so we were down to 50% staffing. We just don't have the capacity and workforce, or personnel beyond the healthcare workforce, to handle any significant surge in a small hospital.

Unger: How would you deal with that?

Dr. Harmon: Well, we look at resources such as me, myself as a family medicine specialist, and we'll look at intensivist, excuse me, not intensivists, but internists, generally speaking, who also feel comfortable managing inpatient ventilators and things like that. We do a lot of telehealth. We've developed all manners of platform, HIPAA compliant, restrictive access type telehealth platforms. And we manage a lot by telehealth these days.

We've moved into the 21st century under pressure here. We wanted to be there, but now that telehealth is upon us, we're utilizing it substantially.

Dr. Srinivas: I have to echo Dr. Harmon on this. One of the huge issues for rural America is our lack of resources. Because over the last two decades we've seen a massive contraction in health care in rural areas, where we now, although we have 20% of the population of the US, we only have 2% of the ICU beds in rural America, which is concerning. Like Dr. Harmon said, I'm the only infectious

disease physician for a 70 mile radius in this area where I live here in Iowa, and we don't have the capacity to deal with the overburdening of the system that could potentially happen with this virus.

On top of that, while we are transitioning to telehealth, which is wonderful, rural areas are also bogged down with a population that's more likely to not have access to a smartphone or proper internet to enable telehealth. So then we're also seeing broadening of inequity as to who's getting care. Even in just my northwest region of Iowa, about 20% of our population doesn't have access to an internet that would enable them to have the telehealth platform where we can interact reliably. So it's all—

Dr. Suk: I think Megan, that's a great point. I think that in our areas in central Pennsylvania, we also run into the bandwidth challenges of telehealth. And one of the good things that'll come out of COVID, I think, is the fact that this is going to be here to stay for all of us, and hopefully, that'll move the ball along forward for greater internet access across broad swaths or rural areas.

I think we when we talk about telehealth as both the video type, but we're finding ourselves doing a lot of telephonic check-ins as well, which I think are not quite as good as having a video, being able to actually see and talk to the patients. But they certainly appreciate the check-ins from their physicians or individual physicians to see how they're doing, and especially with a lot of these visits that have been canceled as a result.

Unger: I'm curious as you look to the experience of your colleagues in larger cities, are there lessons learned that you are putting in the application as you prepare in your own communities?

Dr. Suk: Yeah. For us, I think for us specifically here, a lot of the clinical experience that they're having, that they're having to do under very stressful conditions and on the fly, the fact that we're a little bit behind them gives us great lessons to be able to apply in clinical practice. And so watching the experimentation that's going on with a lot of hydroxychloroquine is very interesting for us. We're looking for the data as they continue to do it. Proning, different techniques for treating pneumonia, using some of the experiences that the Italians have had with using helmets instead of ventilators. We're looking and watching very carefully to see what we can apply here if and when the wave does hit us.

Dr. Harmon: To build upon Mike's answer, one of the things we've learned now and that, unfortunately, we've learned the hard way in this pandemic is that we have real time access to healthcare decision makers. We have real time access to data, to research. We mentioned before we got on the broadcast about textbooks. We don't use textbooks anymore. We use real time learning opportunities. The internet is a great opportunity for us to share good experiences and bad experiences, and so we have decision quality data now on the small rural hospitals and we have made available from the, unfortunately the larger hospitals, the folks in Italy, the folks in New York, we know what works and doesn't work. So we're, if not smarter, we're at least better educated right now.

Dr. Srinivas: Yeah, I have to agree completely. I'm so grateful to our frontline workers in New York, Boston, Seattle, California, the ones who, our colleagues that have been communicating in between taking care of patients, that way we can be prepared. Because it's their words of warning, their data that they're giving us, and that they're taking the time between their exhausting shifts to share. That's really going to enable us to be better prepared to take care of our patients on the clinical front here.

Dr. Suk: Yeah. I think one other really important thing too, Todd, is that the PPE questions that came out very early, which definitely showed huge deficiencies in our healthcare supply chain, I think were very rapidly addressed, and I think we will ultimately be the beneficiaries of that. So while PPE is still a concern for all of us, I know, it's our hope that I think the supply chains will rekindle themselves to be able to staff or at least to provide us with the product we need in the areas that are later hit.

And again, to echo both Gerry and Megan, I mean we owe our frontline providers out in the cities that are getting hit first a tremendous amount of gratitude for the continuous lessons that they continue to share with us.

Unger: Well, thank you very much for this discussion and I wish you the best of luck over the coming weeks as you confront the pandemic.

That's it for today's COVID-19 update. I want to say thank you to our guest today, Dr. Michael Suk, Dr. Gerald Harmon, and Dr. Megan Srinivas, for being here and sharing your experiences with us during this challenging time.

We'll be back tomorrow with another update. For resources on COVID-19, please consult the AMA COVID-19 resource center at ama-assn.org/COVID-19. Thanks for joining us today.
