**Episode 68: Life in the time of COVID**

Dr. Joe Chappelle: Hello everyone and welcome back. I’m Joe Chappelle and you’re listening to Episode 68 of the OB/GYN Podcast. Well, golly I think it’s been a while. It’s a good thing nothing has happened since we last spoke. I’m joking obviously. As you all know, I practice in New York, and to say that it’s been an exciting few months would be underselling it quite a bit. And unfortunately, as we record this, the rest of the country is starting to know all too well what we went through here.

This is going to be a little bit of an unusual show, because I don’t really have a script or really have an idea of what we’re going to talk about, but I did want to talk about where we are now, what we went through and where we’re going, both on a personal and medical level, and I couldn’t think anyone else to have here with me to do that than Dr. Jerry Ballas. So, Jerry, welcome.

Dr. Jerry Ballas: Hello, Joseph, it’s good to see your face.

Dr. Joe Chappelle: You as well. I think we’re going to start tonight and just give an update about what we’ve been up to and what this has meant to us. Like I said, here in New York, obviously we had one of the first true pandemic-level events. Like I said, unfortunately Florida, Georgia and California are starting to see the same thing now, but we kind of went through it first. From a practice point of view, obviously it changed quite a few things but for me personally, I actually got scooped up into the deployment of our resources to manage all these patients. At one point, Stony Brook had like 120% of its bed capacity that was taken up by COVID alone, let alone normal patients that we had in the hospital. And although we stopped doing elective deliveries and that kind of stuff, we still had patients who need to be here for other reasons, so we were definitely stressed. We deployed all our residents and fellows. We ran labor and delivery with just attendings, which was interesting. If you work in an academic center, you know the residents do things and the attendings are there for health and safety.

Dr. Jerry Ballas: They sing off on things.

Dr. Joe Chappelle: Correct. So, our attendings had to learn how to use the computer, really, and admit patients and all the systems. So, it was certainly challenging. Most of my life, unfortunately, was spent sitting behind three computer monitors with six different spread sheets open at any given time. But we got through it. Thankfully in OB, we didn’t really get whacked that hard as far as COVID, but we’ll get into that in a little bit. And now, for the last maybe six weeks or so, we kind of came out of that and have gone back to a somewhat normal life. Started operating again and trying to catch up on all the cases that we tried to get done. And of course, we’ll see how long we can do that before things get shut down again. But, starting to get back to normal.

So, like I said, on a personal level, my family is safe, everyone I know is safe. But we certainly worked real hard and had a little bit of stress there. Jerry, how have you made it out? And I know that, obviously, things are getting a little worse where you are now as opposed to a couple of months ago.

Dr. Jerry Ballas: Yeah, no, I think we learned pretty quick, seeing the experience going on, on the East Coast. I think California initially, our area in particular and our institution were, I feel, quick to act. It’s interesting to look back now, because I feel like when we were living in it real time, day to day, it felt like we were way behind. The PPE discussion was probably one of the most fiery early on. And I actually give our nurses probably the biggest credit for advocating for a supply chain and getting us PPE. They were the most vocal early on, and honestly, looking back, they were being told they were overreacting to want to wear masks all the time. They were told they were overreacting about wearing N95s for vaginal deliveries. There was a lot of early… Looking back now, you just want to shake some of the administrators you heard one these Town Halls, but it was a very fluid situation.

We knew that a lot of decisions being made were based on supply chain and worry of running out and causing panic and having people run out and buy up all of the masks they could. And so, I think we were fortunate though, that the wave was slow to get here, because we took a little time to really enact some of the more stringent mask-wearing policies and screening people coming into the hospital. We were a little slow to stop elective cases compared to other parts of the country. And even… We had Washing State, obviously going through the initial wave. Northern California, the Bay Area, started going through their wave. And we were still somewhat isolated. Even LA County. LA County went through their surge. Somehow, San Diego remained somewhat of a bit of a pocket. But once we did shut down elective cases, the residents…

We kept our residents in their usual spots, but definitely pulled back, created different teams, pulled them from many elective rotations, pulled them for many of their satellite sites, because we go to Kaiser as well, and created basically a bench and starters, to put it into sports terms. And I give them credit too. The residents, they were on board with everything we did, and I give their directors credit for keeping them safe. Because it’s very tempting in an academic institution to also march your trainees to the front line, because that’s where they are all the time. And they’re usually very go-get-them type of people. They’re young, they’re healthy. But I give credits to the leaders to pull them back.

And the city itself, we went into lockdown pretty quick. There was a good amount of solidarity at first, but I think like everywhere else in the country and now even more so, we’re seeing a lot of that fatigue set in. And I think that’s what we are now seeing ourselves pulling back and getting probably our surge at this point. And I feel like the walls are caving in a bit, finally, on our bubble, because a lot of our border town regions, Chula Vista, South Bay, Tijuana, El Centro, a lot of our Imperial Valley areas, they’re pretty much at capacity. They’re starting to have to farm out patients. And then a lot of our more community hospitals around are starting to fill up. So, the anxiety has just been continuous. It really has. It’s never reached panic, but it’s never reached calm for a good four months now. And it’s been a surreal experience.

Dr. Joe Chappelle: I want to talk about PPE, but before, I want to ask you a question, because here, we basically didn’t really have anyone go out with COVID. We didn’t have a single Ob/Gyn go out, and I don't know what your experience there was.

Dr. Jerry Ballas: My story is actually I was on labor and delivery hanging out in the resident room. This is really early on, when things were starting to heat up in the East Coast. One of my generalist colleagues was telling a story of how her and a bunch of her friends had a girls trip to Colorado, back when we used to do that, and interestingly, she came back and a few days later, she can’t taste or smell anything. This is well before this is even identified as a symptom. And so, she had gone to the ENT, gotten worked up, had all sorts of things done in the span of a week since coming back to investigate this lack of smell and taste. And we were all sitting around the resident room on labor and delivery, this is before masking, social distancing, bla, bla, bla. And then, news comes out that… In the vaguest of ways, you get a phone call being like, “You may have been exposed to…” And so, that was when the first red flag went up. But honestly, since then, we have not had… nobody caught it from that interaction and our institution in general has an extremely low provider and employee infection rate.

But I look at that also, across the board, we better have a very low infection rate, because if you really think of that statistically and epidemiologically, we are educated, privileged, access to being able to stay home and socially distance, we have access to PPE, we have access to all the latest information. So, really, the only spread that’s been happening now is community, always getting it outside the hospital. We’ve been very, very good about not getting it from our known COVID positives or even patients that have ended up being positive after getting admitted, because I think we’ve done really well to read everybody as a PIU pretty quickly.

Dr. Joe Chappelle: Back in the beginning of this, Beth Garduno, one of the docs here, actually our residency program director and co-resident with Jerry and I, she was pushing from the very beginning that when we have this rate of community spread that is going up and our prevalence is going up, if we don’t have universal testing – which back then we did not – then we don’t know who’s positive and who’s not positive. So, we should treat every single patient as if they’re positive. Especially labor and delivery, because we are actually one of the few units that’s getting a real slice of population. Because they come in there not because they’re sick, they come in there because they’re in labor or whatever else. We’ll talk about it in a second with testing, but if you want to actually see what the prevalence rate in your county is, look at the positive rate in women being admitted to labor and delivery. That’s probably going to tell you what your prevalence rate is.

Dr. Jerry Ballas: And that’s what we’re learning now with testing becoming… Everyone’s all acting surprised that the fastest rate of positive tests are in the younger, healthier populations, because we, for the longest time, thought it was only older, sicker people getting it, because that’s all who we tested. So, I agree. I think, if you could and it took a while to get the universal testing on labor and delivery… I mean, pregnant women in general – and you’ve heard me say this before. Pregnant women are the cross section of your society.

Dr. Joe Chappelle: Correct.

Dr. Jerry Ballas: Hands down. If you want a biopsy of your society’s health, you take a sample of pregnant women and see how they’re doing. And so, I think we were a little behind in doing universal screening and probably would have had a better idea of what actual prevalence this disease is. Because we’re seeing it now, without a doubt.

Dr. Joe Chappelle: Right. So, she pushed that we should treat second stage in delivery as an aerosolizing event, and there is some disagreement about whether it’s aerosolizing or not, although there’s no real good data on either side of that argument so, fine. But she said, we have the N95 masks, which we’re reusing. Why not just use them for everybody and protect ourselves? And I really credit her pushing us to do that with the fact that people did not get sick, especially in the beginning, because our April rate, 5% of all of our deliveries – that’s when we started doing universal testing, was actually halfway through April – and 5% of our patients were positive.

Dr. Jerry Ballas: Wow.

Dr. Joe Chappelle: And so, before then, 5% were positive, we just didn’t know it. And so, she really pushed us to do that. Now, we’ve continued to that, continued to use N95s for all vaginal deliveries and all c-sections and second stage. Unless they’re COVID positive, because now we are testing everybody, we are not… If you’re COVID positive, we use the N95 for that event and then we throw it away. Actually, they get recycled now. But if they are negative, we reuse that mask for the next person as well. Is that what you guys are doing as well?

Dr. Jerry Ballas: Yeah.

Dr. Joe Chappelle: Okay. So, we’ve actually had an internal debate about when do we stop doing that? This is what we have looked at, and I wanted to talk to you about this Jerry, and see what your thoughts are, because we haven’t actually done this yet. So, here’s the first thing. We don’t really know what the sensitivity and specificity of any of any of these tests are for COVID. We don’t know what the negative predictive value is, we don’t know what the positive predictive value is. Obviously, we do know that the negative predictive value and positive predictive value are predicated on the prevalence in the population, and so we can say that the lower the prevalence, the higher the NPV is. But I’ve seen some studies that basically say it has an 85% sensitivity. Okay, so let’s use that. And I did that, and I did some math on that. If there’s a 7% prevalence in your community, that means 12 out of every 1,000 negative tests will be positive.

Dr. Jerry Ballas: Wow.

Dr. Joe Chappelle: So, our institution does 4,000 deliveries a year. So, you look at that per month, like 350 deliveries a month, you say 12 in 1,000, that means you’re going to have 3 or 4 patients every month who are negative, but actually are positive. And if you don’t treat them as if they’re positive, someone in your group is going to get infected, and once they get infected, everyone else gets infected. And so, we’ve been looking at, well, at what prevalence rate do we say we don’t need to take that precaution anymore? If you get to 1% prevalence in your community, then you’re down to 1.5 per 1,000 false negative, which is a lot better. That’s like 4 or 5 a year.

So, that’s what I’ve been thinking recently, about when do we say we don’t do it. And we have been approaching that in Long Island now, about 1% prevalence of our population or pregnant ladies who are being admitted. However, of course now we’re going back into a second surge, so who knows. I want to know if you had thought about that or if you had any thoughts on that?

Dr. Jerry Ballas: I mean, I have not gone into that kind of depth because we haven’t seen those numbers yet. We are now on the slow crawl up. It’s now more… To say 5% in April, I mean, we haven’t reached 5% yet but we’re getting there now. So, I haven’t even thought of the end yet. I’ve barely thought of what it’s going to look like when pretty much every day we are doing a full on N95 vaginal delivery for positive patients routinely. Because right now it’s still somewhat of an event. It really is. I mean, we’re getting more positive patients out. They get tested, they are fine, they are isolated at home, we follow them, they recover just okay. But we aren’t getting the coming in in labor, test positive, routinely yet. But we’re starting to.

I mean, the math sounds solid, but it’s also scary to think that we’ve only seen this for a season and a half right now, and we have no idea how that’s going to continue with every false reopening, with every different change in behavior, with schools going back. I don't know, I really don’t know. I can’t even think of an end at this point. You’ve done a lot more thought work than I have. Kudos to you.

Dr. Joe Chappelle: Well, I’m in a different spot than you are.

Dr. Jerry Ballas: I know. I feel like now I’m in this cynical point where I’m just thinking it’s never going to end.

Dr. Joe Chappelle: I think the reason I even did this is because people started asking, when we kind of started going down in our downslope, is well, when does this end? And I was like, we need to have some definite science, evidence-based way to say, okay, we can stop doing this now. Now, we may not get there for a year, or we may not decide… I personally think it’s going to take a month of staying at 1% for me to be comfortable saying we don’t need to do that. And with our current situation, we’re not going to be there.

Dr. Jerry Ballas: My question is, what’s the motivation for coming up with an end at this point. Like, what is it about the scenario that– Is it cost, is it a desire to just not be as medicalized? What is the push to come to an end already, or want to think of that? Just out of curiosity.

Dr. Joe Chappelle: I think it’s a mixture of resource sterilization. I think it’s also a desire to get back to normal. And people are always asking… You have people on both ends. Some people who basically never want to stop wearing N95s going to the grocery store, and there are people who want to stop wearing N95s yesterday.

Dr. Jerry Ballas: Who already stopped.

Dr. Joe Chappelle: Correct.

Dr. Jerry Ballas: Yeah.

Dr. Joe Chappelle: And so, I think that there is… But there are other people who advocate for stopping, and you have to have an answer for them.

Dr. Jerry Ballas: Right. Okay.

Dr. Joe Chappelle: And that answer to me was, okay, we’re going to go with 1% and when we stay at 1% for a month, then we’ll talk about stopping. And until then, we’re not going to talk about it. And to me, that was a way of addressing the issue without… Because otherwise, they just keep stirring the pot up about all that stuff.

So, you’re doing universal testing, you’re wearing N95s for all deliveries or just for COVID positive?

Dr. Jerry Ballas: COVID positives. And PUIs.

Dr. Joe Chappelle: We’re doing all deliveries because of this false negative rate.

Dr. Jerry Ballas: Because of the false negative rate, right. And I mean, I would not be surprised if we end up there because of the scenario you talked about. Our background prevalence rate is rising. In terms of the testing, I can’t tell you off the top of my head what their–

Dr. Joe Chappelle: No one knows, that’s why.

Dr. Jerry Ballas: Right. And so, I wouldn’t be surprised, if it gets bad enough, we’d have to go to that, if the false negative rate is really going to start becoming that concerning. And we’ve been reassured that our supply chain for PPE and N95s is solid. We’ve really gotten over that initial hump of really trying to ration it. And so, we’re not quite there yet, but right now the party line is COVID positives and PUIs.

Dr. Joe Chappelle: And then for the positive women that you’re seeing, at least here, probably 95% of them are asymptomatic. I don't know if your experience is similar.

Dr. Jerry Ballas: Yeah. I mean, asymptomatic or mild symptoms.

Dr. Joe Chappelle: We’ve had some anosmias.

Dr. Jerry Ballas: Right. I’m dealing with that right now. Persistent one, with an accreta who’s due to get delivered in two and a half weeks, lives all the way out in the Hinterlands but has this persistent anosmia and keeps getting retested, which is a whole other universe of questions that we have in terms of do we keep retesting?

Dr. Joe Chappelle: When you’re no longer infectious.

Dr. Jerry Ballas: Exactly. So, that one’s an interesting case that’s coming ahead. And so… What was the original question?

Dr. Joe Chappelle: About asymptomatic.

Dr. Jerry Ballas: Yeah. Interestingly, the first experience I had with a COVID positive patient was the doomsday scenario of being helicoptered in from a community hospital out East, intubated, mid-trimester somewhere or other, nobody had information on her, already had the ground-glass appearing lungs, all sorts of interventions, ICU-based, and that’s how I met COVID. And to me, I was like, well, this is the avalanche. And that ended up being our sickest, most intense patient to date. She ended up getting… she’s the one that taught us how to do the trip from the ICU to the OR in the safest way and donning and offing, and the OR routine. So, she was our test case and she’s pretty much been our only severe case like that. We’ve had a couple go to the ICU for support and concern for respiratory issues, but nothing to the extent that she was.

Dr. Joe Chappelle: That’s funny, because we had a similar experience, where our first two or three were the sickest and since then, it’s been mostly mild.

Dr. Jerry Ballas: Right.

Dr. Joe Chappelle: But I think it shows you that in the beginning, we were only seeing the ones who were really sick, because they were the ones that were coming in. Now, because we’re testing everybody, we’re seeing all the milds.

One of the things we’ve seen, probably the two things that have been the most consistent of the asymptomatic women, one was oligo, and the other was transaminitis going along with preeclampsia. And we know that transaminitis goes with COVID even in non-pregnant women, but certainly in pregnant women, makes it complicated because then you don’t know if it’s COVID or it’s preeclampsia. But oligo, we’ve seen – I have to go back and look at the charts – but I think maybe 15 or 20% of our asymptomatic women with COVID were also oligo at term.

Dr. Jerry Ballas: We’re just now starting to routinely scan post-positive COVID tested patients. I haven’t seen that pattern come out, but they just released a large population study showing that the IUFD rate has started to go up. And they just released the French paper showing, in utero vertical transmission. So, the evidence is there that this virus is going to affect pregnancies at the placental level. There’s no reason to think it wouldn’t. It’s a highly active vascular illness. So, I wouldn’t be surprised if we start seeing– We’ve instituted now any positive patients end up getting routine growth NSTs and AFIs in the third trimester, so we’ll start collecting more of that data and seeing if we have a pattern, but to date I have not heard anybody put that two together, that the COVID positive patients are having oligo, or even any kind of fetal non-reassuring status through our screening so far.

Dr. Joe Chappelle: We were talking before we started recording, about placental analysis. We just need to go back and look after we have a few hundred or a few thousand charts and looking at these placentas of women with COVID, asymptomatic and not and see if there’s any placental evidence of…

Dr. Jerry Ballas: Yeah, it’s funny and sad, but that first case I was talking about, the actual patient that taught us the big picture of how to treat a seriously sick COVID pregnant lady, the one mess up from the case is we lost the placenta. Our placental pathologist was livid. We searched everywhere, and we realized one of the weaknesses– and, in general, when you are delivering your patients outside of your house, outside of L&D, yeah. Main OR folks are not used to treating specimens the way we treat them. So, yeah. It went to the garbage. Very sad, very sad. So, now, we have in big bold letters everywhere, “Placenta to pathology,” in all these patients.

Dr. Joe Chappelle: But then, I know you said you’re still experiencing your flare, so you don’t have a ton of experience outside that first sick lady, but I know you also read all the ACOG and AJOG and SMFM and everything. So, I wanted to know what you’ve seen about evidence as far as treating these pregnant women with COVID.

Dr. Jerry Ballas: Well, we still have all our trials running here, but there are all ongoing trials, and so there is no set protocol at this point outside of what you see for regular non-pregnant populations in terms of treating with remdesivir or hydroxychloroquine or anything that’s been coming up. Now, dexamethasone is interesting. We all hear dexamethasone and we all perk up. And I think that is actually on the list of potential treatments, we just haven’t had the patients to try it out on. But that would be, I mean, I think for OBs, once we started seeing dexamethasone data, that actually became a little more comforting that we may have something that we are very familiar with, very comfortable with, and in the worst case scenarios have a potential treatment that shows some promise.

Dr. Joe Chappelle: We’re doing D-dimers here and treating with Lovenox. D-dimers because of the VTE.

Dr. Jerry Ballas: No, we’re not formally screening through serum testing, but if they are COVID positive and in the hospital, somewhat immobile, if they’re just ill and in bed, we’ll do some anticoagulation while in the hospital. We still haven’t come consensus with how long we keep them on it. Do we keep them–

Dr. Joe Chappelle: There’s no evidence.

Dr. Jerry Ballas: Right. Through the symptomatic period, through three, six weeks after being symptomatic? It’s still up in the air. And then, in terms of if they deliver by section having been recently positive, we probably will. That would be my leaning, would be at least prophylax in the postpartum period.

Dr. Joe Chappelle: Right. And then, the next thing I wanted to talk about is actually changes to healthcare, and this is not just Ob/Gyn, but certainly affects us as well. I mean, we were basically the only practice that didn’t shut down out of Stony Brook, because we had pregnant women who had to be seen. And we had some GYN patients that needed to be seen. And I should say medicine was open a little bit, and pediatric was open a little bit, but basically any annual routine visit was gone. And so, we were probably the busiest practice, and so we had to reinvent ways of taking care of these people. And that took a few forms, and I just want to talk about a few of them and you can tell me about what you guys are doing there.

But it starts with the simple, if they don’t need to come to the office, don’t come to the office. And so, we ended up doing a lot of telehealth. And that took both the, I guess what you call the traditional telehealth, which is a video Skype sort of thing, we use Teams, because that’s the product that we have. And we said, all of our new OBs, we did Teams now, we did telehealth for new OBs, and do all their intake and education and then we would send them a script in the mail and they would go to the lab and get their blood done and then come in for ultrasound at 10 or 11 weeks. Now, we’ve gone back to doing dating ultrasounds that are traditional, like 7, 8, 9 weeks. But during the peak, we were just doing the 11-week, unless they had issues.

And we also did a lot of telephone telehealth for post-op visits, even postpartum visits were being done on the phone or by telehealth, because most of those are really counseling, they’re not really exam based. And also, we did some GYN, like vaginitis, UTI symptoms, we would do those on telephone or telehealth. But even in our office, the patients call when they get here, we check them in over the phone, they stay in their car, when it’s time for them to come in, they come in by themselves with no visitor, they go right into the exam room, we have mask on, we have to wear eye protection…

Dr. Jerry Ballas: Oh, yeah. We just rolled out eye protection, like literally two days ago.

Dr. Joe Chappelle: It’s obnoxious. But eye protection, the patient wears a mask, everyone gets screened for temperature, including all the healthcare personnel and the patient. And we reduce our schedules, so we basically never have people crossing in the hallway if we can avoid it. And really have just tried to reduce the density of the people in the office and the patients. And it seems to have worked pretty well right now. So, I don't know what you guys are doing down there.

Dr. Jerry Ballas: Well, once the overarching enterprise really kicked it in the gear to allow for more telemedicine, I think that had always been one of the hang-ups, the whole reimbursement and…

Dr. Joe Chappelle: Regulation.

Dr. Jerry Ballas: Regulations. And once those went away, there was a lot more freedom to come up with those kind of plans. So, I actually took part of the lead for presenting to the faculty a way to introduce telemedicine to our prenatal care, because we really never had. Nobody really was using telemedicine routinely except actually our diabetic educators, were probably the most active in at least telephone encounters and keeping up with our diabetic patients. And so, I talked to them a lot about how patients respond to that, and they always gave positive feedback, that the patients, rather than slugging in all the way to a visit, et cetera, that they found it very convenient. And so, I looked online. There are some institutions out there that have really – not so much perfected it – but created pretty good pathways and so, yeah.

We made an initiative to – similar to what you guys do. A lot of GYN stopped. MFM was probably the only one that pretty much stayed the same, if not a little better than expected. But we really limited, obviously, no visitors, everybody in masks. We didn’t do temperature checks, we did question-based screening at the doors. We had our waiting rooms, but they were severely reconfigured to not allow more than like two people in it at a time. Our NSTs, that was another thing, we had to really look at our NST protocols, because we do a lot of twice-weekly NSTs. A lot. And so, we really had to look at that with a fine toothed comb and figure out when it was comfortable to limit, go to fetal kick counting for a lot of the things we do twice-weekly NSTs for.

But one of the bigger challenges was the technology side of it, because we have telemedicine through MyChart, through Epic. And so, there is a few steps involved in terms of having to do the visit through Epic and the patient on the other side has to be through MyChart. So, the Epic-branded MyChart portal has to be done through that. And so, that was one sticking point, because for some of our patient population, I had to spend half the visit literally downloading the app on their phone, creating a username, password, with a translator. So, it was a challenge. And there was a lot of resistance, because people, right off the top, assumed, oh, our patients aren’t going to be technology savvy enough to do it, it’s more of a pain. Nobody had really been trained in how to do this. Meanwhile, Regina, my wife, for those who don’t know, she’s pediatric neurology. And they went over from Kaiser and Rady’s switched over to remote and telemedicine fairly quickly. Kaiser does a lot of more telephone than video. Rady’s did a lot more video. But they were much more facile than we were. And so, yeah.

We looked at first trimester and decided, at least for high-risk patients, that first visit is pretty important to at least see what the problems are and figure out what they need to do. We started incorporating our ultrasounds as prenatal visits, especially between 16 weeks to 20 weeks was important to have their quad screen drawn so they could either get that done at their anatomy ultrasound. So, obviously we wouldn’t have their quad screen results for the sequential screening at the time of anatomy, but they could leave there and get it done from there. And then we instituted blood pressure checks at our ultrasound units for the later trimesters, so at least we had that data point. And so, you could spread out, especially the mid-trimesters. We’ll do telemedicine in four weeks and we’ll see you back in the office in eight weeks.

Dr. Joe Chappelle: Yeah.

Dr. Jerry Ballas: I feel like it was really getting traction, we had good data behind it. There really wasn’t much patient pushback. In fact, a lot of our patients, especially as the news got scarier out of the East Coast, and especially as they got used to that technology, a lot of them really preferred it. And then, the whole talk of reopening and getting back to normal happened, and I feel like a lot of the gains we made over those two months have now just pulled back. So, we don’t do as much telemedicine as we had done previously, even though now technically, we’re surging and having a higher prevalence of COVID. So, I don't know what to make of that. I mean, I think we learned quickly to be with our social distancing, masking, we’ve done a great job, I think, thinking it at bay. That, even though the prevalence in the community seems to be rising, we’re still staying steady in our little bubble of the hospital and clinic. I just don’t know when that’s going to be breached, is what I worry about.

Dr. Joe Chappelle: Yeah. I mean, you sound like we’re doing very similar things. And I agree, our patients, they love to telehealth new OB visits. Absolutely love it. And we’re starting to pull back. We’re pulling back on all of our telehealth, except for the telehealth new OB visits. I think we’re going to continue that forever, because patients love it, because it really is a counseling visit, they don’t need to be there in person. And it helps us get them in faster, because we can say, okay we have telehealth tomorrow morning at 9 AM, you don’t have to travel, you can do it from your office. Not that anyone’s going to the office yet. But you could do it from anywhere you want. So, what we do is we have our clerk or MA call the patient 5 minutes before their visit and says, “Do you have the app? Is it installed? Yes, everything’s good.” Then, at the time of the visit, the MA gets on the call with them first, make sure they’re all set up and then pass it over to the doc, so the doc is just going.

Dr. Jerry Ballas: Yeah, see, we don’t have that. And that’s, I think, one of the sticking points. I think that’s one of the reasons the perception hasn’t been as positive from the providers’ side. Another question, how are you scheduling them with your in-person visits? Do you have a segregation of sessions? Like, all telemedicine for a certain chunk of time…

Dr. Joe Chappelle: Yeah. At the beginning, they tried mixing telehealth and in-person visits, it did not work.

Dr. Jerry Ballas: No. It doesn’t work at all. And that’s what I was arguing and getting some traction until we started pulling back on telemedicine visits. But I was arguing, we need to have either… because we work, from my perspective in resident clinic, we should have a resident that’s assigned to telemedicine visits for the session. That’s their thing. Their MA does what you talked about, is ready to do the call, get on the phone… Regina’s MAs at Rady’s, Regina’s at home, the MA’s somewhere, either at home or in the hospital, they get on the phone with the patient first, then they let Regina know that she’s ready and then goes. Just like you do a regular visit. We have not incorporated our MAs into that, and part of it was because we simply were having, here’s two in-person visits, sandwiched in the middle is a telemedicine visit, then your in-person. And I just don’t think it caught traction that way. I mean, I understand why. It should be all in or all out, I think, for a session.

Dr. Joe Chappelle: People liked it much better when it was all one…

Dr. Jerry Ballas: Yeah.

Dr. Joe Chappelle: If anyone out there is either looking at doing telehealth or in the middle of it and hating it, try separating it and doing one or the other. People like it much better. I mean, in our particular practice, our new OBs are all done by NPs, so it’s different than the MFMs are really doing consults or ultrasound.

That kind of leads me into the next question, I guess my last question is where do we go from here? And I recognize that you and I are in two different spectrums, although… Hopefully we’re in different spectrums because three weeks from now I can be in the same place that you are and that we’re going back up again. But what have we learned or what are we learning from this that we can really apply going forward? I think some of it is the new OB, and some of it… I think what you’re saying… What do they say, necessity’s the mother of invention?

Dr. Jerry Ballas: Yeah.

Dr. Joe Chappelle: And so, we are learning that we are capable of doing things that we never thought we could get done because it’s necessary. And I like some of the energy. We’ve changed more things in the last three months than we did in the last three years.

Dr. Jerry Ballas: Oh, yeah.

Dr. Joe Chappelle: And some of it we’re not keeping because we didn’t like it, but a lot of it was positive. And we never would have tried it if not for this crisis. So, I don't know. What kind of lessons do you think that you guys are learning institutionally or personally over there that you’re going to take with you?

Dr. Jerry Ballas: I think it’s along what you’re talking about. I think we are more flexible and resilient than we think. And I think technology… Just like COVID, I think has pushed other realms of society faster, I think technology in medicine is going to be one of them. I really think that the ability to use remote technology… First off, we know that it can actually be a way to make access a little more equitable if done right and investment is put into it. So, getting our ability to reach harder to reach populations, further out populations. Telemedicine is not a new concept, but there’s never been that fire to really promote it. The traditional doctor, white coat, office paradigm…

Dr. Joe Chappelle: You come to me.

Dr. Jerry Ballas: Yeah. Has always been the predominant paradigm. So, I think that’s one of the bigger things, technology coming in. I think flexibility and people really being able to work together in really uncertain times I think is going to a be a huge focus of teambuilding and the way you put teams together in the future. I think just relying on been there, we know what we’re doing, this is how we’ve done it for a long time, I think you can start seeing the dangers of that. And having some flexibility is going to be key going forward, because this isn’t going to be the last thing that’s going to push us in the next few years.

Dr. Joe Chappelle: One of the things you can easily apply from this, is… It’s like at Stony Brook and you also, I’m sure you have a similar thing there in your clinic population, is we have people who take three or four buses to get to the clinic.

Dr. Jerry Ballas: Yep.

Dr. Joe Chappelle: And half of those visits can be done telehealth.

Dr. Jerry Ballas: Correct.

Dr. Joe Chappelle: Everyone has a cellphone these days, everyone has a smartphone, and all it takes is either a website or an app, and you can do a telehealth visit. It’s easier to get access.

Dr. Jerry Ballas: I went so far as to start calling them i-visits. I was like, you know what? Maybe we have to get rid of the old terminology, because what the hell is a tele? Like, a telephone? Do we have things telephones anymore? I think if you actually start wrapping your mind around… And you say telemedicine and people just envision this awkward staring at the screen and talking like… No, what you’re literally doing is opening up your practice in a modern way, just like the car brought people to your hospital rather than you going to their house, now we’ve come full circle. There is a way for you to actually do home visits, which I think is one of the classic physician callings, is to be able to literally be in someone’s home to help them. And so, I think modernizing the lingo around it, modernizing the thought of what it can do… One of my older colleagues would be like, “Oh my God, how are you going to know what her blood pressure is?” And I’m like, “Amazon will deliver her a blood pressure cuff.” You can get Bluetooth blood pressure cuffs that will tell you what her value is. It’s all there, we just need the will to invest in it. And it comes as easy as just changing the name.

Dr. Joe Chappelle: Words matter, as we have learned, amongst a lot of things, recently. I think the other thing, and it goes into, I know, another passion of yours, is the fourth trimester. There are so many opportunities for i-visits in the fourth trimester, because a lot of it is counseling and just checking in, and what issues are you having and what resources can I get you? That don’t involve an exam. Even a postpartum, quote/unquote, “exam,” is mostly BS. What are we doing? Okay, if you don’t have any complaints about your breasts, I’m probably not going to find anything abnormal if I do a breast exam. If you’re not telling me that you’re bleeding heavily, I’m probably not going to find anything when I do a pelvic exam on you six weeks after you delivered. And same thing for perineal exam.

Dr. Jerry Ballas: Right. And even in more complicated things. One of the more popular high-risk situations is the blood pressure check. Come to the office for a blood pressure check. And Melissa Wong just had a great editorial in OB Management that’s talking about modernizing the blood pressure check. And they presented at SMFM, there was a lot of data to show that text-based, app-based reporting from your patients from their blood pressures…

Dr. Joe Chappelle: Better.

Dr. Jerry Ballas: Yeah. First off, you actually keep contact with them, because expecting a new mom with a new baby to come traipsing into the office freshly from delivering a kid, we already know 30% of those women are not showing up. But 100% of those women are going to be looking at their phone at some point during the day. So, if you make something as easy as sending me your blood pressure by test, having some triggers for abnormal numbers, now suddenly, you have more women that you’re analyzing and you’re targeting the right women that actually do need to be seen or evaluated. And I think postpartum visits are some of the most classic types of visits that were built for home visits. So, let’s do that through i-medicine, virtual medicine, I don't know what to call it. V-clinic, i-clinic sounds like the ENTs probably cornered that one, or the ophthalmologists. But you know. I agree, I think you can really provide the type of counseling that I think postpartum women need without the intrusive inconvenience of having them pack up everything, especially in the age of COVID.

Dr. Joe Chappelle: Right. Because they’re not going to be their baby, which means by the time they actually get seen, they’re really going to really need to breast feed and be uncomfortable.

Dr. Jerry Ballas: Exactly.

Dr. Joe Chappelle: I guess we’ll bring it back to COVID to finish up. I want to, I guess, reiterate some of the things that we’ve learned here at Stony Brook for the people out there who are maybe just going through it or haven’t gone through it yet. And we talked about them, but I just want to recap.

If the prevalence in your community is going up and your institution can do universal testing for every woman admitted to labor and delivery, you should do that, because you don’t know what the true prevalence is in your community without that. And there’s probably plenty of positive women who are asymptomatic that are exposing your staff that you don’t know about. And I can understand if you don’t have… Testing was a big issue at Stony Brook for a long time, so I understand if that’s an issue at your hospital as well, but I think we should all advocate for that if possible. If you do not have that, then you should definitely advocate for wearing N95s at the minimum and eye protection for every single delivery until you know who’s negative and who’s positive.

If you have a high prevalence, even despite having universal testing, I still think you should wear PPE for all vaginal deliveries and c-sections, because again, there’s going to be a non-trivial false negative rate, because we really don’t know what the qualities of any of these tests are, because there is no gold standard, so we may not know for a year or two. I don’t even know if the test from Roche is the same as the test from somewhere else. And so, I don’t trust anything.

And I think if you do those two things, you’re at minimum protecting you, and your staff, and your colleagues. And I think that’s the minimum that we should be doing. Again, we are… Anyone who works in OB, especially at an administrative level, understands that no one understands what we do, no one understands that we are different than the rest of the hospital. People don’t come to labor and delivery because they’re sick, they come there because they’re healthy having a baby, and so it’s a very different population than your 75-year-old who’s coming in with a cough. And so, they need to understand that we’re different, that we have to be treated different, and the policies may not be the same across all the different units. So, those are my big takeaways. And then look for things like oligo. If you’re not doing universal testing and you’re only testing for symptoms, look for things like oligo and say that maybe that’s an indication to test, because we have definitely seen that here. Look for the anosmia and the other soft symptoms if you’re not doing universal testing. That’s what I have Jerry, I don't know what you have.

Dr. Jerry Ballas: To piggyback on people don’t know what we do and so forth, one of the sadly funny moments early on in this, in one of our Town Halls, we invited our institutional infectious disease doctor to listen to our concerns about N95s in delivery. And she’d gone so far as to try to break down the difference between an aerosolized particle versus a… what was the term? Now I’m forgetting the term. Anyway, it got to the point where she called one of the attendings that was arguing for N95s in delivery, hysterical. And I’m like, do you know the origin of that word and the irony right now of calling us hysterical because we want N95s for vaginal deliveries? I think right there was just proof to your point, that people really don’t know labor and delivery. In fact, when the ORs came out with a lot of their protocols for COVID positive patients and all their considerations, they forgot that labor and delivery does surgeries, and they didn’t even include us in any of those protocols or any of those different supply chains, because they forgot that we do surgeries on labor and delivery. And so, yeah. I agree. Don’t settle for institution-wide standards. Look to our individual, unique situations on labor and delivery, because we are.

And then always, we use the baby as an end organ screen for so many other things, like growth restriction to look for placental function. So, I agree. I think the baby can actually give us a window into what may be going on at another level than we can just detect with classic symptoms. So, that’s why anybody COVID positive, it’s helpful to take a look and see fetal wellbeing, get pictures, follow those fetuses, because we still don’t know what kind of hit the placenta takes. Whether it’s a Zika picture, where the placenta can become a reservoir for this virus, we have no idea. And I think the French paper coming out about vertical transmission in utero is going to really, I think, accelerate a lot of the fetal assessment in COVID patients.

Dr. Joe Chappelle: Agreed. The issue is we just don’t know if it’s 1 in 1,000 when that happens, it is 1 in 100,000, is it 1 in 10? We don’t know.

Dr. Jerry Ballas: And, is it gestational age related?

Dr. Joe Chappelle: We don’t know anything.

Dr. Jerry Ballas: Right.

Dr. Joe Chappelle: Jerry, I want to thank you for coming on today, doing this… Almost our first episode of 2020, I think I did one back in January. I am going to try to get back and do this more. I’ve been actually meaning to do this for a couple months. I recognize that we’re all sitting here in lockdown, and some of us more in lockdown now than others, but we’re all… I mean, I’ve been listening to a lot of podcasts myself trying to distract myself or other things. Unfortunately, this wasn’t a distraction from COVID because we talked about it a lot. But I am going to try to do some more episodes now that my brain is functioning again after my time in the wilderness.

But I encourage you, if you do have something you want us to discuss about this or any other topic, if you have concerns, if you disagree with that we said here, please email me and I’ll be happy to talk about it on the next show. I would be happy to make the next few episodes a dialogue on what’s going on in medicine, in Ob/Gyn during COVID, or I’ll do an episode on diabetes, which I have to finish.

Dr. Jerry Ballas: Is that still around? Diabetes?

Dr. Joe Chappelle: I hear that there’s still some common medical issues that happen. But I’m going to try to do some more episodes, we’ll do some journal clubs, we’ll try to get back to some kind of normal. So, even if your life, dear listener, is not normal, you can have a little bit of normal from us. So, we’re going to try to do that. And I’m sure Jerry will be more than willing to help me do that.

Dr. Jerry Ballas: Oh, absolutely.

Dr. Joe Chappelle: So, thank you Jerry. Thank you all of you, I hope that you all are staying safe. That if you need the resources, that your institutions are listening. If you need evidence, if you need data to help back you up, I’m going to try to put some stuff in the show notes for this, but maybe on the website. There’s a Facebook page that Jerry pointed me to months ago now, that has lots of great resources for Ob/Gyns, the CDC, SMFM, AJOG, ACOG, I’ll put it all up on the website and in the show notes for the podcast so you can go there and go to your institution with backup or just validate what you’re saying. Jerry, any closing words?

Dr. Jerry Ballas: Yeah, just to piggyback on the Facebook page, I give Chris Han at UCLA credit for starting that up. It’s really focused on OB leadership on labor and delivery units and within administration, and it’s been an amazing place to crowdsource data, crowdsource experiences similar to what we’re doing on this show, talking to people from across the country, geographically, even locally, to get an idea of what’s going on at different places, because sometimes you can feel like an island. You feel like you’re taking crazy pills, is what I keep describing. That’s been my number one description of how I feel some days, where you think you’re overreacting. You’re looking around and you’re like, is it me? Should I be less worried? And then there’s other days where just kind of like, what was I thinking? Why am I not wearing a full hazmat suit right now? And I think having a resource like that, which isn’t a general, wide open kind of Facebook group, but a much more focused group of people involved in decision making at the admin level, at the residency level, fellowship level, so it’s a great exchange. So, we can post that, and there’s an entrance questionnaire that Chris Han and the moderators go through, but I highly recommend it.

Dr. Joe Chappelle: Yeah. It is really designed for leadership. And leadership can mean, if you’re a community hospital and you’re the Ob/Gyn… Even if you’re not necessarily in charge, but you’re the person who ends up making decisions, that can be you.

Dr. Jerry Ballas: Exactly.

Dr. Joe Chappelle: You don’t have to have a title.

Dr. Jerry Ballas; In fact, they encourage, I mean, one of the biggest outreaches we wanted to get to were the community hospitals, where you sometimes feel disconnected from us in academic institution. And so, we’ve had some great community voices. Randy, actually, Randy Terkowitz, she is one of the movers and shakers in her private hospital in Pennsylvania, and she’s, I think, benefited from the site and also contributing greatly. So, yeah. I think take a look and see if you feel it’s the right fit, we welcome your voices, because this isn’t going away any time soon.

Dr. Joe Chappelle: Absolutely. Alright, well with that, thank you jerry. Thank you all of you. Like I said, it’s going to be back. I am safe. I did get a couple of emails questioning whether I was safe or not, and I am. And I hope that you all stay safe, and I look forward to talking to you again soon.