TMC PULSE

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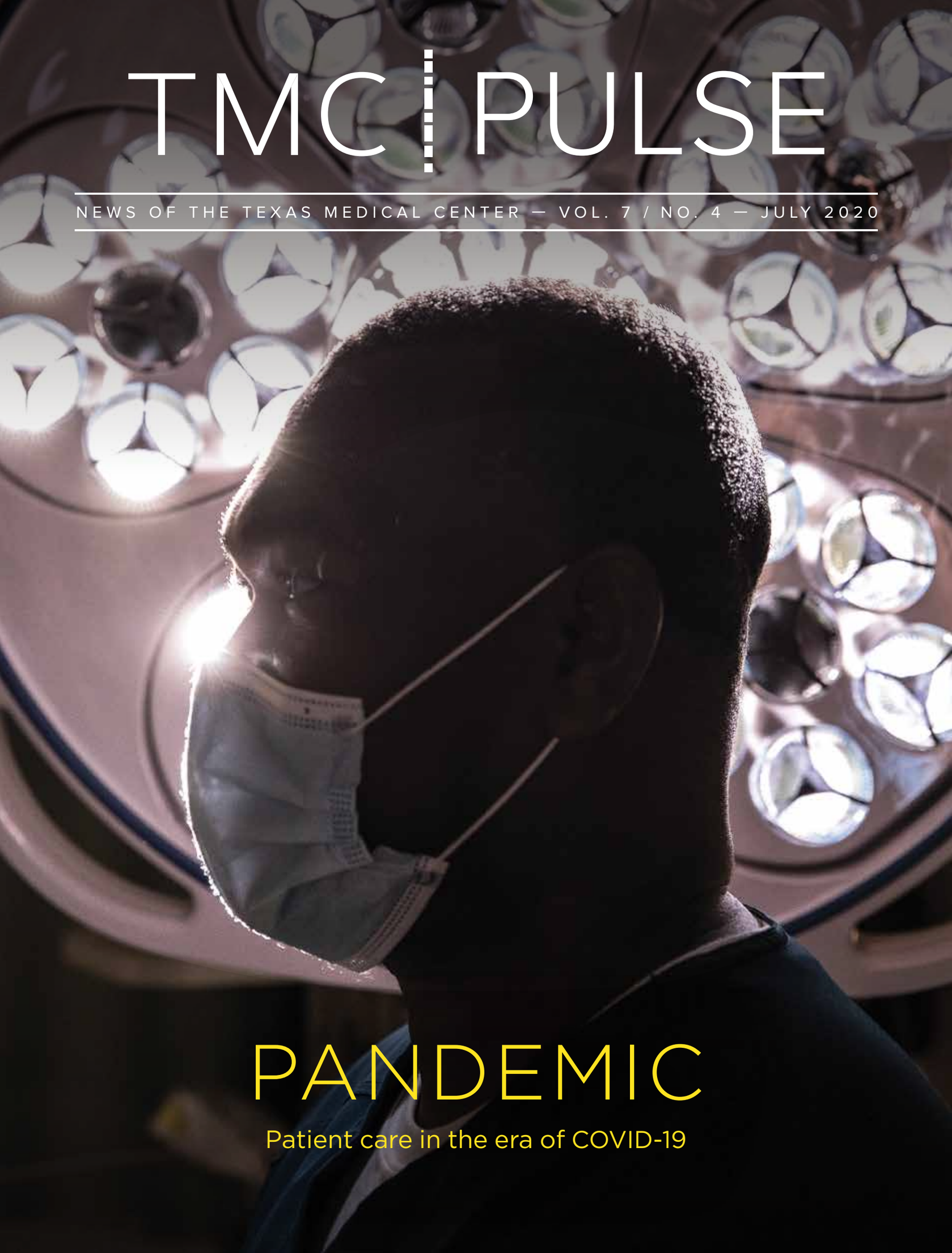

PANDEMIC

Patient care in the era of COVID-19

Baptism By Pandemic

Harris Health System's new leader, Esmaeil Porsa, stepped into his role at the onset of the COVID-19 crisis

By Cindy George

In early March, just as COVID-19 was emerging in Houston, Esmaeil Porsa, M.D., MPH, MBA, began his tenure as the first physician to lead Harris Health System. The former executive vice president and chief strategy and integration officer at Parkland Health and Hospital System in Dallas assumed his new post at the start of a global health emergency that has had a disproportionate impact on Harris Health's Ben Taub and Lyndon B. Johnson hospitals. Yet Porsa's decades-long experience serving patients in safety-net health care settings has energized his commitment to underserved populations during the global pandemic.

PULSE | Why were you interested in the CEO job at Harris Health?

PORSA | My entire life has been devoted to public health and, even more than that, population health. It was just the right fit at the right time. In my interviews, when they asked me why I wanted to come to Harris Health, the honest answer then and now is: I think I can help.

PULSE | You've spent some time professionally in Houston before. Tell me about that.

PORSA | I did my training in internal medicine at The University of Texas Health Science Center at Houston. I actually spent most of my training at LBJ Hospital. After that, I worked for one year as an ER attending at LBJ and, in 1998, I started working as UT faculty inside the Harris County Jail. I provided primary care inside the jail and also ran their infirmary for several years while I was teaching epidemiology and statistics at McGovern Medical School.

PULSE | Why did you leave Houston?

PORSA | In 2007, I was recruited to Parkland Hospital in Dallas to become the medical director for the Dallas County Jail. I did that for about six years and then I was promoted to senior vice president for medical affairs. During the move to the new Parkland Hospital, I became the interim chief medical officer to ensure the successful transition. About four years ago, I became the chief strategy and integration officer for Parkland Hospital and held that title until I came back to Houston.

PULSE | What's your analysis of the elevated importance of public health amid COVID-19?

PORSA | The impact of COVID-19 on the segment of the population that the Harris Health System cares for is so much more significant. The percentage of the patients in my hospitals who are COVID-19-positive is more than twice the proportion of patients who are COVID-19-positive in any other hospital in this area. Think about this segment of the population: They are racial minorities, they are underinsured, they are uninsured. They are those who have chronically suffered from not just social disparities but also health disparities—and they are now being more severely impacted by COVID-19. I think COVID-19 is shedding a light on the impact of a pandemic on a community that has chronically had a lack of access to adequate care.

PULSE | Can you elaborate on the inequities, the special purpose of Harris Health and, respectfully, the greater burden?

PORSA | It *is* a burden. I was talking to another reporter the other day who asked if we were suffering a higher burden because of the number of patients. The answer is no. While the rest of the hospitals in this area have basically been empty until recently when they opened their doors again to elective procedures, the hospitals in Harris Health have been full. Several weeks ago, one of my hospitals was over 100 percent capacity. We were basically creating rooms in the emergency room to take care of our ICU patients. The proportion of ICU patients with COVID-19 has come up to 14 to 15 percent across the TMC, but 44 percent of ICU patients at LBJ Hospital are COVID-19-positive [as of early June]. That's almost half of all ICU patients at LBJ. The percentage is less at Ben Taub just because it's a larger facility. The burden is not so much the number. The burden is the fact that a much higher proportion of the patients are COVID-19-positive and they are just more difficult to care for in a regular inpatient or ICU bed.

PULSE | How do you approach your job under these inequities in the era of COVID-19?

PORSA | I am relying on my education and training in public health. My hospitals have been full, they will continue to be full and that is just a constant struggle. It is our mission to care for the segment of the population who don't have access to care otherwise. That's who we are. That's what we do. We will never use that as an excuse to provide anything less than the highest quality care for our patients, because they deserve it. As we do that, we should also be cognizant of the fact that if we are going to fulfill our mission to improve the health of the community, we also have to pay special attention to not just managing disease and treating patients, but think upstream to do what we can in disease prevention and health promotion. Why are our patients so sick? That goes back to the chronic lack of access to health care and the social disparities that exist. We have to address those things.

PULSE | Are you able to work on prevention during this pandemic?

PORSA | We are doing probably 2 percent of what really needs to happen. All hands are on deck trying to address COVID-19. We started testing the homeless for COVID-19 because that could become the next hot spot if we have homeless people in close proximity who are chronically ill or in poor health.

PULSE | If Harris Health System is doing well with population health and health promotion, what does that look like?

PORSA | We prevent disease onset. It would be ideal if we could prevent hypertension and diabetes,

but what if we could do something to postpone the onset of hypertension and diabetes by five years, by a decade, by two decades? Both the financial impact and the health impact of that on our community would be immeasurable. Those are the types of things I'm excited about and what I want Harris Health to become known for.

PULSE | Finally, can you provide more details about the conversion of Quentin Mease, the former hospital in Third Ward that is transitioning to an outpatient facility focused on dialysis and HIV care?

PORSA | Dialysis is one of my passions. It's going to expand our dialysis program with a focus on peritoneal dialysis [blood purification during a process in the lining of a person's abdomen] and not so much hemodialysis [blood pumped and purified through an artificial kidney machine], even though that program is going to expand. I want to be well known in this community and nationally for doing peritoneal dialysis well. The difference in overall costs and mortality is huge. There's less mortality and morbidity—infections and things of that sort—with peritoneal dialysis, as well as the ability to perform the dialysis at home and to travel and to work. But how do we treat the diabetes and hypertension that cause people to end up in end stage renal disease? The best thing would be to never get to the point of end stage renal disease and that goes back to upstream thinking and prevention.

This interview has been edited for clarity and length.

IN THEIR OWN WORDS

Voices from the front lines of the pandemic

CEDRIC DARK, M.D., MPH, assistant professor of emergency medicine at Baylor College of Medicine, spoke to *TMC Pulse* on May 11, 2020.

The biggest problem we have with COVID-19 is that it can be transmitted asymptomatically by people. You don't know who has it. You don't know if you have it or not. When you're out and about around people, you need to wear a mask so you don't unwittingly spread it to somebody else.

My advice is the same thing Batman told John Blake in 'The Dark Knight Rises:' 'The mask is not for you; it's to protect the people you care about.'

We've got to realize we're in this entire thing together, and we're going to be in this for years. Until people start behaving like it, more and more people are going to die from this disease. Every time someone goes walking around town, enjoying life as they used to without making any kind of modifications, they're potentially killing someone else down the road—whether it is someone's elderly parent, grandparent or a health care worker. That's what happens when you have arrogant people doing things and setting poor examples for others.

This is the new normal. I've been saying that for a while now. Our old normal can't function anymore until we get a vaccine. That's going to take one to two years to happen, so we're really talking 2022 before we get back to normal life. By then, after two years of living like this, it's not going to be normal. It's going to feel different.

At the hospital, patient volumes will pick up again, but COVID-19 is going to be in the background of all this for a long time. The idea that I can go on a shift without an N95 mask all day is pretty much done until we have a vaccine. I honestly think that every single ER doctor and ER nurse around this country is probably going to walk around with a mask on all day long for the foreseeable future because you can't walk around and know who has the coronavirus and who doesn't.

Our most valuable resource in health care is our human resource. That's one of the most important things we have to protect. Because once your doctors and nurses are dead, then what do you do?

People only notice public health during times like this, but the real work happens when nothing is going wrong. This is why you have people in one administration create a pandemic office to address these kinds of threats, and then the next administration gets rid of it because they forget what is happening in the background.

How many times has your house caught on fire? Should we get rid of the fire department? It's the

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exact same thing with public health. Just because your house doesn't catch fire, doesn't mean you don't need the fire department. Just because you haven't had to call the police for any reason, doesn't mean you don't need a police department. We need public health just as much as these other departments because we're taking care of things that range from water purity to mosquito-borne illnesses to human-borne illnesses being spread from person to person. That is not something that is easy to do.

—Cedric Dark, M.D., MPH,
as told to *TMC Pulse* writer and columnist Shanley Pierce

"We've been able to allow family members to visit their dying loved one when hospitals couldn't."

GABRIELLE STATEN, RN, BSN, an associate patient care manager for the inpatient unit at Houston Hospice, spoke to *TMC Pulse* on April 22, 2020.

We had to implement restrictions because of COVID-19, which included an age limit on visitors. Right now, patients can only have two visitors at a time, and they have to be 13 or older. We had to put some kind of limitation on it for the safety of our patients and staff, but we wanted to make sure patients still got to be with their family members. We had the option of saying 'No visitors,' but we couldn't do that.

We have a patient in his mid-40s who has three children, and one of them is only 10. But we don't want to prevent children, especially, from seeing their parents prior to their passing. So, our social worker went to our director of clinical services and our CEO and got permission for the young boy to go into the garden and see his dad through a window. We put the son through the same screening everyone goes through and brought him through a side entrance and into the garden. Because the boy was going to be masked and the dad was going to be masked, I said that the boy could go ahead and go out into the garden with the dad, because our gardens are set up for beds to go out there. So, instead of just seeing each other through the window, they were actually able to hug on each other and spend some time together.

Just seeing that little boy with his dad—it took me back. I lost my mom when I was young and letting him have that moment, it means everything.

It's not something we can do for every patient. Like any exception, it was on a case-by-case basis, but in a time like this I'm so thankful we can allow visitors at all. We've been able to allow family members to visit their dying loved one when hospitals couldn't.

Just the fact that we were able to do something that makes a huge difference in a person's life—it was wonderful. How can you describe a moment like that?

—Gabrielle Staten, RN, BSN,
as told to *TMC Pulse* senior writer Alexandra Becker

RICARDO NUILA, M.D., is a hospitalist and teaching attending physician affiliated with Ben Taub Hospital and Baylor College of Medicine. He spoke to *TMC Pulse* on April 13, 2020.

As a clinician, you feel the tremors of COVID. It's not a linear course, like what you expect when giving antibiotics to a patient for an infection. With COVID, the oxygen level goes down a bit and then you don't know where it's going to go from there. The patient gets a little bit better one day and you have hope. Then the next day things regress and you think, 'Wait a minute. No.'

The first COVID patient I saw must have been three or four weeks ago on a night shift.

One of the particularities of hospital medicine and hospitalists is that we admit patients from the emergency room and we're the people responsible for those patients up until they require a ventilator. I think the stats show that for every person who goes to the ICU [intensive care unit] there are two or three patients who are managed by hospitalists on the floors. So it's really one of those situations where you want to be the only doctor a patient sees, because if that patient sees other doctors it's usually ICU doctors and that means that things have taken a turn for the worse.

And here's the thing: The doctor is in a privileged position. The doctor sees the patient and then writes orders and those orders are implemented by other people. So the doctor manages how much exposure there is to COVID in the hospital. All orders engender more exposure, so you have to weigh all of your choices really carefully. COVID causes you to be as efficient a diagnostician as possible.

There was one patient at Ben Taub, she had a week of sudden onset cough and she was clearly short of breath—oxygen levels low. The COVID test came back negative, but we know there are false negatives and you just have to reckon with that. Are you going to push for a different diagnosis? There came a point where I had to say, 'Let's look for something else.' We did find something else and it was an even worse diagnosis than COVID. Those are the difficulties we face.

This pandemic has put a premium on patience. We don't have any known therapy against COVID, and I think there's an inclination in all doctors to feel unsettled by not giving certain treatments or by not actively trying to solve an illness. Patients can be on oxygen in the hospital for a while and you can't bring them off of the oxygen. This illness can just linger. I think physicians need to ask themselves: Can I be patient? Is the breathing getting better or is the breathing getting worse? Can we wait another day before sending the patient to the ICU, where they may need to be put on a ventilator? If we're not worsening, can we just continue to keep doing the same thing?

Ordinarily, the health care environment is about getting things done and getting things done quickly. With COVID, you have to train yourself to do less and observe more. It's an era of uncertainty and that has made being a doctor very difficult.

After Hurricane Harvey, I went to care for some of the displaced at the George R. Brown Convention Center pretty early on, when we just didn't know how many people would be coming in. You saw people who were shivering. You saw people who were still wet from being rescued from the water. At that point, before we had a plan to get people medications and tell them where to go, the best you could do was reassure them, to say, 'You're OK without your blood thinners for one day.'

In that way, COVID is similar. One of my COVID patients told me he always felt good when we spoke. That made my day because, other than the oxygen, the most that I could give that person was my attention and my words. But that's also the case with everybody in the hospital right now because there are no visitors. Even with

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non-COVID patients, you have to be aware that they are alone. I had a patient who was elderly and awaiting major surgery and she's there, alone, without her family. She's a non-COVID patient, but it's the same. So your job expands. I've always felt like this was part of the job, but I feel like it's all the more important right now to focus on making the patient feel like they have an ally within the hospital walls because they can't have the physical contact with people they love and rely on for decisions.

Another surprising thing is just how differently different doctors and nurses interpret new information. It feels like everything is confirmation bias right now. Let's say a new COVID study comes out and it doesn't clearly point in one direction or another. Somebody thinks about it and says, 'Well that reinforces what I previously thought about COVID.' Everything is so scattershot that people are just using whatever is written out there to confirm their own preconceived ideas about illness and philosophies of medicine. Science takes time and we're forcing science to produce answers too quickly.

That's why I really believe we should be focusing on the person in front of us as much as possible, because if you start to think about all of what's written right now, you'll just go crazy.

It's an interesting time to be a doctor at a safety net hospital because there's a clear message with COVID, which is: Save as many patients as possible. Save them all. America does not usually send that message clearly. In a health care environment with so many uninsured people, there are conflicting messages and questions, such as: Should people be receiving health care if they're not insured? There's something relieving about treating COVID patients because you know your job is just to do the best that you can.

—Ricardo Nuila, M.D.,
as told to *TMC Pulse* editor Maggie Galehouse

STELLA E. CALLEGARI, BSN, RN, a nurse at the Michael E. DeBakey VA Medical Center, was reassigned as an outside COVID-19 screener during the pandemic. She spoke to *TMC Pulse* on May 16, 2020.

Before this, I was working in physical medicine and rehabilitation on the second floor, where people would come in for their spine clinic or musculoskeletal appointments, acupuncture or the chiropractor. But now, I have shifted outside along with the other nurse from the department because the clinics aren't running like they were before.

I had been wearing a face shield, but honestly, the plastic on it had gotten cloudy. I can't see through it like I had been because I've wiped it down with alcohol so much. Now, I wear some kind of goggles. Sometimes I will just wear glasses. I always try to have something.

Now that people are wearing masks, I'm not so concerned that something is going to fly out of their mouths.

When the patients come in, I'm pretty much the first person they see with these other nurses who are out there on computers. We get it all. They're either complaining of diarrhea or having some kind of cough or this or that. We have to shift them over to the COVID provider who is out there—either a doctor or PA [physician assistant]—near the building. We will walk the patient over to an area where there is a vital sign machine and hand off a report and find out what their vitals are, especially if they're having hypoxia [deficient oxygen supply to the body] or a high fever. The provider out there will decide what to do. Sometimes, they go off to the ER where they do a rapid COVID screening.

Sometimes, patients don't realize their appointment has been converted to a telephone appointment or by Zoom. We have to explain to them what's going on and what we're doing with the social distancing to help prevent people from spreading COVID. We make sure that the phone numbers in the computer are up to date so that when the provider calls them, they are able to reach them. Pharmacy and mental health are outside with us. Some of these patients have to go in for their methadone or for injections for schizophrenia, so they have to go upstairs to do that. If they have pharmacy refills they need, they can go directly to talk to them.

I'm at the very front where the Metro bus comes in under this overhang. There are a couple of tents. I'm not under one of those, so when it rains, that roof thing kind of leaks. We have to keep shifting our computers. Sometimes, the shade goes away and the sun is right at me, so I have to keep using the computer in a place not right under the sun. It's interesting because I usually work in a department where there are no windows. So, when I come in, it could be one way and when I go out, it could be cold or hot. I just never know. And now I'm out there all the time. It's been cold, hot and humid, rainy, windy—just everything.

It's been an interesting experience also because I am working alongside nurses from the primary care clinic that I'd never met before. I feel like we've come together. Sometimes, we have patients who come for chemotherapy and radiation. They have to come on a schedule every day for those treatments, so you start to learn who they are and what they're there for. They get used to seeing you. When they finish their treatments, we applaud them. They give us their certificates and we sign our names and write 'God bless you.' Even though there's a terrible thing going on, I have enjoyed having this interaction with patients outside.

I am honored to serve our veterans.

—Stella E. Callegari, BSN, RN,
as told to *TMC Pulse* assistant editor Cindy George

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