Transcript
Coronavirus Q & A – Episode 15
July 17, 2020

Edward Brubaker: Good afternoon! Today is Friday, July 17, 2020 and this is episode 15 of our almost-weekly videos that we do here for Living Branches and our website. It's good to be with you today. I'm not Alex Metricarti. I'm Ed Brubaker. We switched roles this week. I'm sitting in for Alex as she's having some well-deserved vacation. We have an honored quest that we'll introduce in just a moment.

As we typically do as the beginning of these videos, we give an update with where things are within Living Branches related to the coronavirus. This week I'm pleased to report that we continue to see improvement at The Willows of Living Branches. We currently have four persons who are positive. Some of them have had their first negative test, but we want to go through the protocol of having two negative tests for each person who had been positive before we say the facility is clear again. We anticipate that happening within the coming week. But we feel good about where we're at currently. We also have one positive continuing at Park View. The resident is currently not in the facility, but they are, we hope eventually coming back to the facility. But we do have one person there. The Dock Woods campus continues to be clear of COVID. We are very pleased about that. That campus was hit the hardest during this process and during these times over the last few months. So that's the update for where we are today in Living Branches. Again, we appreciate the hard work and efforts of our staff and really making things happen over the last number of weeks and scrambling into action at The Willows as we had the positive cases there, creating a red zone for the COVID positive residents. So we are very pleased with where things are at the moment here at Living Branches.

One of the things we usually give an update on, too, is things that may have happened in the past week, significant happenings. There typically is something to talk about and this week is no different. CMS announced this week that they are planning to provide point of care testing equipment to all 15,500 nursing homes across the United States. We do not know all the details of that or when we will get those test kits for Living Branches. They did say they're going to be focusing on states that are hot zones and areas where they're working at there. So we don't have dates for that, but we're doing some research ourselves to say, how can testing be part of our ongoing protocols as well, to try to ease up some of the restrictions that have been in place. So more to come, I'm sure, over the next number of weeks as we update people on that, but that was the big story on Action News this week, to hear what's happening coming out from CMS. So we look forward to providing updates on that over these next weeks.

Today we are very pleased to have a special guest with us. The honored guest we have here is Dr. Daniel Haimowitz.

Daniel Haimowitz: Just a regular guest.

EB: Just a regular guest? Ok. Just a regular, very humble guest, Dr. Daniel Haimowitz. He is our medical director for Living Branches. And Dan, it's very good to have you here today. You've been here, what? Three-Four-five years?

DH: It's been three or four years, yes. Time flies.

EB: Time just goes so quickly, it's amazing. Certainly you came to us after our previous medical director, Paul Moyer, retired. It's been great getting to know you over these last few years. And you are a person who is focused on medical direction. I believe you do follow some patients, as well, but one of the things that attracted us to you was your focus on being a medical director as well and really focusing on that. And so I'd like for you to give some updates for people. A lot of people don't know who you are, and just talk about your background and your experience.

DH: You want me to talk about me?

EB: In 30 seconds or less.

DH: I'll try. Ok. I'm actually honored to be here. I went to college at Penn State. I went to medical school at Jefferson Medical College in Philadelphia and I did my internship and residency at Thomas Jefferson University Hospital in internal medicine. I didn't actually realize there was a geriatric specialty so I went back home – I was born and raised in Levittown. And I just found my place in nursing homes. So I've been very active in my community and actually I've expanded to do things both in the state and nationally for long-term care medical direction. And when this happened four or five years ago, Dr. Moyer who has been a good friend of mine for many years – like one of the original geriatricians in Bucks County – and I got my boards in geriatrics about four years when I came back home. He said, "You'll love it. You'll love Living Branches – it's great." And for those of you recall Dr. Moyer, he's usually right and he was right again. It's been terrific working with everybody here.

EB: Great. I think there was a common connection, too. A Brubaker out of Lancaster that you knew. They're a long-lost relative, well maybe not long-lost, but anyway there were connections across the state as well and so you came with high recommendations.

DH: There's a huge Brubaker family tree that I didn't know about. But one of my best friends is Dr. Brubaker in Lancaster. Any Brubaker is a friend to me.

EB: It's great to have you here today. And talk a little bit about the pandemic and what we've been going through. That's what we want to focus on today and get your perspective as a

medical director for us but also your perspective in the industry. I know you're involved with AMDA and PMDA and many other organizations, too. And so you really do come with a wide variety of experience and a good background which has been very helpful to us. As we think about this pandemic that we're going through now. Many time when people were talking about a pandemic they were referring to the 1918 flu. And I know we're both getting older, but neither of us lived through that. And so we really don't have a modern equivalent of a worldwide pandemic. Certainly there's been Ebola and other things, but this is really the first time in my lifetime – and I think we're around the same age – that we've really experienced it. So as you think about this and reflect on it, what has been, from your perspective, the most difficult thing through this process?

DH: I think it's interesting – when I first started in practice, as it turns out I was talking to a lot of my patients whose parents died and it turns out they died in 1918 and I didn't know what that meant. But it turns out, because of where I am in time, that I realized about the 1918 flu epidemic before most people did. Now they have. I'm also medical director at a couple other facilities – my office is in Bucks County, so I'm medical director at the Attleboro community in Langhorne and another Personal Care in Yardley, where we had a terrible outbreak there. Not nearly as bad as what we had here. I think the hardest thing in all this – and I think everybody will agree – is watching people get sick, and a lot of times, die and not be able to do anything about it. By far, this is the worst experience of my professional career.

EB: That's right. The pandemic of 1918 hit younger people more and this one is hitting older folks. Like you said not being able to do anything about it. But also the experience of dying without your loved ones around you. I know that's been something that any number of people have talked to me about. It's very difficult.

DH: Agreed. It's a terrible, terrible thing. Not just that the family is not around - because this is almost as hard on the family as it is on the residents. But even when they die, that you can't go to church. Jewish people have a Shiva. It's something we have never experienced before. And I hope it never happens again. It's so dreadful.

EB: I would agree with that. As you think, too, about your experience with Living Branches and you're part of the coronavirus response team that we put together – boy, I guess that was in March already that we were putting that together.

DH: Feels like a lot longer than that.

EB: Yeah, right? It's crazy because it feels so long, but it also feels short. It's this strange juxtaposition of that. But what would you reflect on some of the things, maybe, you felt went

particularly well in Living Branches? And as you reflect, too, what are some things that you say, wow, I wish we could have done that a little bit better.

DH: Well, I hope it's not sounding self-serving, but I'll tell you my honest answer is me as a person, I'm very detail-oriented and I obsessively plan. As it turns out – who knew? – that some of the administration in Living Branches feels the same way. And that's not the norm – to obsessively plan. So I think – first I was thrilled to be involved and part of the coronavirus response team and as administration. I always sit there and have notes, I have plans. That's not what the usual person does. And I think – and I mean this honestly – it has been a really *really* good thing to work with all of the teams very collaboratively – all members of the team – and plan ahead. I mean, we've learned things. We spent a lot of time, a lot of hours doing this. I asked my wife, "What do you think could have been done better?" Her answer was: not spend so much time obsessively planning and spending so many hours on phone calls. So I don't see what we could have done better. A lot of this is – if you go retrospectively and knowing what we know now, could we have done things different? Well sure. But you didn't know it at the time. So I don't think you can go back and say – one example is masks. If we knew now – I think many more people would have worn masks. We didn't know that. I think in general one of the tones we've been striking with the coronavirus response team is an overabundance of caution. So I think we went to many things ahead of time. But going back, what could we have done different? I don't know what you think, but I don't see what we could have done.

EB: You're right, too. We were learning a lot along the way. I hear that sometimes on the news. Well Dr. Fauci was saying this back in March and different in April. The bottom line is we're learning. Particularly early one we were learning new things by the hour sometimes, by the day. I remember one time you and I were talking at 11:30 p.m. on a Saturday night about some of these things. We were constantly learning. And even the intensity of that I have seen is changing on the coronavirus response team, too, over the last few weeks because we now have things and plans in place. And things that we were dealing with in the beginning – it was crunch time.

DH: Completely agree. I think looking back – and you look at the media and the focus initially was on hospitals because they just didn't realize there really would be a focus on nursing homes. And then if look at what we've learned. We've spent weeks talking about skilled nursing, skilled nursing, health care, health care. When it turns out a bigger problem is probably Personal care, but we just didn't know that. And I think, too, I think how everybody looks at it here. It's not a political thing. We do and we should remove any kind of politics. I think what we've tried to do is look at the science, which is the best evidence. And in all cases try to do the right thing. Try to prevent illness and save lives. We struck that tone from the beginning, I think.

EB: That's right. And I remember early on, too, I read an article in the Inquirer by Dr. Josh Uy that you know so we were able to get him on the phone, Dr. Wright from Canterbury out of Richmond, Virginia and you were making connections. So the thing I found with you, too, is with

being a medical director you have contacts all over the country – Dr. Wasserman in California, the President in PMDA.

DH: Oh Dr. Dave Nace. He's President of AMDA now.

EB: Exactly. So all of these different connections that we can learn more. I think Josh – Dr. Uy was the one early on talking about the cohorting ideas and segmenting residents.

DH: And so did Dr. Wright in Virginia. I'm very self-deprecating. I like to accept blame and give praise to other people – it's my leadership style. But I'm a moderate size fish in a small pool of geriatricians involved in medical direction. One of the nice things about COVID is a lot of medical directors around the country have really stepped up to the plate. So I'm like a connector and I know lots of people. And it's sort of like being at Living Branches. I don't know if I'm necessarily that smart, but I shine in their reflected brilliance. Right? Present company included. So I just know lots of people. So when I find somebody I like, you know, I say hello, I make a joke, I get their cell phone number. So it's really great I think if we can do this. I think stepping up to the plate – I've always believed in the concept of medical direction which involves the medical director as an important part of the administrative team. And not all places do that. And I mean this sincerely to Living Branches' credit, they have done that. So I think there's lots of opportunities here as this progresses.

EB: That's absolutely true. And I would observe sometimes, in fact I had a friend who was asked to be a medical director in a different state. It was kind of like we'll pay you $1,000.00 a month to come in sign some papers and we need to have a medical director. It was kind of like this idea that we're going to meet the rule, the expectation under the law that we have a medical director. I guess, I'm of the mindset that if we're going to have a medical director and we're going to pay them, we want to get value out of it, too. But also see them as an integral part of the process as well, as opposed to, oh we can check that box to say hey we've got that covered.

DH: It makes me laugh because you saw my 1950s style office, which was my dad's office.

EB: Yeah, that's right.

DH: One of the things I like, I've said – my wife, again, hates when I say this – money doesn't mean anything to me. She hates that. But to me, more important, is being a good medical director. Because what you're talking about is unfortunately the standard at a lot of places. Because it's a requirement in nursing homes to have a medical director. They come in to attend meetings, sign papers, and admit patients. And I think there is so much more that an involved

medical director can do. So I just feel like – and again I think that's the philosophy of Living Branches which is you want to do the right thing for the right reason. A good medical director along with a good administrator and a good director of nursing, accepts responsibility, follows through, communicates well with people, does the right thing, looks to other people if there's a best practice – so there's all kinds of things I think an involved medical director can help. And I try my best.

EB: That's very true. I agree. We're very much in the thick of this. In some ways it feels we're in a bit of a lull within Living Branches because we were hit so hard in late-April, May, and June, particularly at Dock Woods and now we've had some cases at The Willows and a few at Souderton, but very minimal. But it feels for me that we're in a bit of a lull. Depending on where we read about other states, 19 or 18 have travel restrictions to Pennsylvania and you see the things happening that we saw in April in New York State, and people talk about the second wave and all these kids of things. We really don't know what the future will hold but we need to keep doing the right thing. As you think about what we as staff, we as residents can do, that families can do, as we look at easing restrictions and have already done with some of them – what are key things that we should be paying attention to really keep each other safe and keep our residents safe.

AH: I agree. It's like the eye of the storm. It was terrible, now is the lull, and you worry about what's coming next. I'm not sure – Is there going to be a second wave? Are we still in the first wave? It's all worry. We worry about what's going to happen at the end of the year if influenza comes and you have flu and COVID at the same time. I don't want people to worry about it, but to your point, I think we just need to be cautious. We talk about this in coronavirus response team – you look at the lesson learned from states that opened too early. By doing that, you wasted all the effort that you did for months ahead of that. So I know this is a really hard time, but I do feel like the staff, the residents, the families in this community want to do the right thing and understand that. So what's the right thing? Take personal responsibility. Wear your mask. Keep social distancing. Wash your hands. The very basic principles of infection prevention and control. So continue doing this. Be cautious. If you wonder about something, don't take the risk. I think this will pass. I hope this will pass. I would love it if the virus would magically disappear. I know people have said that. I don't think it's going to, but if it did that would be wonderful. I think we're going to have to wait on the developments you talked about – testing. I think that the vaccine we talk about all the time. We have to be educated. My friend Dr. Wasserman in California – they say: Stay prepared. Stay informed. Stay calm. And I think that's a very good motto. Wear your mask right. Wear it over your nose. That's what I see all the time – people aren't doing this. Don't go out if you don't have to. And the important thing – remember who is at risk. I'm doing a lot with other people around the country and they're talking about – they recognize the trouble that it is to people who have not been getting out, who have been alone. There's no question. I think we're working on that, but the whole idea of patient-centered care, which I very much agree with – it's a fine balance. You know, if someone doesn't want to get tested and they don't want to do that. It's somebody's right to not do the right thing, as long as it's not against the law. But there's other people you can put at risk, so I think it's trying to look at the whole bigger picture and strike the right balance. But I really think we need to continue to remain vigilant.

EB: No, I agree. And you touched on the mask “thing” if you will. Part of me says why do we even have to call it a thing, let’s just do it? Someone said if we introduced seatbelt legislation today people would probably scream about that too, but –

DH: But they do! Motorcycles. People scream about wearing a helmet.

EB: Exactly. Now in that particular case the person not wearing a helmet is more at risk that someone else. But simple things like the seatbelt. I remember as a kid we never wore seatbelts in the car. I remember being on family vacations and trying to crawl back on the back ledge and all that kind of stuff. Today it’s just standard practice. You pull it on. It’s interesting how those things come about.

DH: How they evolve with time.

EB: Exactly. And thinking of Georgia where the Governor was suing the Atlanta Mayor about the requirement – really duking it out over state power versus mayoral power. And it’s like just wear the mask. Just wear the mask. We’ve talked about this on previous videos, too. I’m not sure why it’s so hard.

DH: It’s the politicization of it. I don’t know why it’s become this way. Look, people can agree to disagree on politics, but I don’t think wearing a mask violates your constitutional rights. I didn’t see that in the constitution. I watched Hamilton – I didn’t see it there either.

EB: That’s right. I read a physician’s perspective that said if we would all just wear a mask and wear them properly that we could temp this down in two months’ time. Now is that two? Is it three? Who knows! But at the end of the day, I think we know enough now – let’s just wear the mask and try to do it. I think it’s just very important to do that.

DH: And I think it’s important to not assign blame. Dr. Fauci said at one point not to wear masks. But that was back in February when nobody knew things. I just think it’s important. Let’s not blame people. Let’s do the right thing moving forward. And I think the vast majority of people are saying wear a mask. I was looking up directions to make sure I got here OK today, on time, which I did, right? And I was looking at Google maps, and Google maps pops up with this thing that says, “wear a mask”.”

EB: Did it really?

DH: It did. Excellent.

EB: That's funny. That's great. Seguing a bit to testing. I know you and I have talked about testing a lot. Unfortunately there are still challenges to testing and getting it turned around quickly enough. I know you and I have talked about it would be great to have a daily rapid test and all these kinds of things. It feels like we're moving in that direction and certainly announcements from CMS is welcome news and we'll see the efficacy of those tests. But can you talk about how you see the potential of good onsite testing – that we're not there yet – but how that could be part of our way to ease restrictions and manage this pandemic.

DH: We've talked about this from the very beginning. The whole goal of what we're doing to is to keep somebody who hasn't had COVID from getting COVID – period. That's the issue. I think we've learned you know, we kept families out, we were on lock down. But many places still got COVID, so who that was – couldn't be from anywhere else – had to be from people coming into the buildings, right? So you think that is where the danger lurks. I think it has become very clear that the risk of that becomes greater with the more COVID you have in the community. So the more COVID you have in the community, the more likely it may come into the building. In an ideal world, there would be a test that you could get, utopia, like finger sticks that you do for blood sugars. But I don't like the idea of a needle. I'd rather do something over the skin. Boom you do the test, right then and there, and it tells you whether you have COVID or not. Again, you know all these things. The trouble with COVID has been a large number of people who don't have any symptoms. So if you have somebody who doesn't have symptoms, they don't know it, you do the screening – it only catches people who do have symptoms. So ideal world, someone comes in and you can check them. Not just staff – anybody who visits – which includes family. Not I'm not saying you can't have family. I think there's subtleties that you have to tease out of this. For example, best case scenario: you have a resident who has had COVID and is recovered. You have a family member who has had COVID and is recovered. Let's talk about ideal. Both have an antibody test – both have antibodies, which means they've both had COVID, they're immune, they're not infectious. Well if you could figure that out, in theory, they could visit. I think that is the challenge. Because what happens now is you have regulations. You may know this – people from the higher-ups in the department of health have an edict that says thou must do this without any direction for how to do it. That's happened.

EB: Yes.

DH: So what you do is, if you can tease out these subtleties – there's a lot of people working on it. Because what happens is phase regression – you know you're in phase one, phase two, phase three, you get one positive test which could be negative and it moves everybody back to the beginning. So I think everybody is working really hard on this to take everybody's different priorities into account. And how do you do the right thing, while not putting people at risk or greater risk.

EB: That's right. And with the testing, too, I was doing a little bit of research today and we have a person who does project research for us here for Living Branches – so I'm working with her to do some of the research, too. But was looking at some of the things today about the rapid test that we're supposedly getting from CMS. And it was very interesting to watch that, that you could get results back fairly quickly and just thinking about how that could be somewhat of a game-changer, even for families and other people. It would be logistically challenging and I'm not even sure how much the equipment costs at this point, but honestly, it's worth the dollars in my opinion unless it's just astronomically priced, to help us create a way of being able to live with COVID.

DH: I completely agree.

EB: It's kind of exciting to see what's out there. And I have enough faith in scientists and people in technology working at this stuff. It may not be there but it will continue to move there. It's kind of exciting, actually, to see what the possibilities are.

DH: Agreed. Right now I've read about these tests that give results in 15 minutes. Which right now, our screening is you get your temperature checked instantly and then you can come in. So you'd have to wait 15 minutes and you'd have a COVID-pending area. How much is it going to cost? How accurate is it? But we've talked about point of care – you've talked about it for months now. So I agree it's exciting. The devils in the details. Let's see how it works. You know. So I agree.

EB: Yeah. Well thank you, Dan. It's been good to be with you today. One thing I'd like to ask you before we do close, is reflecting on your own work and working with seniors primarily. What is it that makes you passionate about the work you do and passionate about serving seniors?

DH: That's a good question. I don't know. What makes a person passionate? I can't say. It's just – I didn't even know there was geriatrics when I was in school. But as a kid I always seemed to like my friend's parents more than I liked my friends. So I've always been drawn to older people, I don't know what to say. And I've always been a self-starter. I've always been highly motivated. And I don't know – I've always loved the elderly. When I went home after my residency, my dad had four patients in nursing homes. Two in one and two in another. And within a year it was up to 100 because taking care of residents in facilities just suits my talents. So I've been able to do, and this isn't about me, but I've been able to do so much more than I've ever dreamed of. I've gone to national conferences. I'm one of the countries experts on physician care in Assisted Living. The reason is because there aren't very many. I could say I wrote the book on Assisted Living. Well I did. I wrote a book chapter on Assisted Living. I feel like – and you can look at this different ways – but when you move up in a community you can affect thousands of lives. On a state level you can affect tens of thousands, maybe hundreds of thousands. At a national level

you can affect hundreds of thousands, maybe millions of people, which I think is amazing. The fact that I have the opportunity to do this, to work with other doctors and organizations is just incredible to me. I also think, too, is there that big a difference between that – working on a national level, writing a book – versus taking care of and supporting one family. When someone is at the end of their life and you are supporting their wife through the end – is that any less important? There are a lot of good, wonderful, important things that one can do in geriatrics and people can tell right away that I'm so enthusiastic about it. I don't know how I lucked into making such a terrific life choice. I talk to students. I talk to residents. I say, look long-term care is the greatest job for a physician. So why am I passionate about this? I don't know. But it's been one of the best decisions I've ever made. I couldn't ask for a better profession, in my opinion.

EB: That's great. That's wonderful. Thank you. Thanks for sharing. It's also interesting you can feel young, too, when you're in this role as well for quite a while. Even when others may look at you as old. I'll never forget – and I'm in my upper 50s now – but this was when I was in my late 30s, early 40s – probably early 40s and I remember specifically it was the same day I was coming to pick up my daughter after something at church and one of her friends was joking about how old I was, but earlier that day someone where I work here at Living Branches, Dock Woods at that point, was commenting on how young I was. So it's just perspective.

DH: It is perspective. When you look at geriatrics – they always teach you this. Young is 65 to 75, middle-aged is 75 to 85, and old is over 85. So to me, when I get a patient in their 50s, I say you're a spring chicken. When my dad was 84 I'd say, "you're middle-aged!" But you're absolutely right. It's all perspective.

EB: That's right. And I see, too, with our residents. Those that age well are ones that have a positive outlook on life. You can have a 60 year old that feels almost older than a 90 year old. It's very interesting.

DH: We talk about this all the time. 86 is the new 65.

EB: That's right. And it keeps looking more like that as we get closer.

DH: Yeah. The definition of old is 10 years older than you are.

EB: That's right. We have residents over 100, so 110 is old, I guess. Well great. Well thank you very much, Dr. Haimowitz, for being with us today. It's a pleasure to talk with you and a pleasure to have you as our medical director as well.

DH: Thank you. I'm honored.

EB: Thank you. That ends our episode 15 for today. Thank you all for being part of this and watching. We hope it was informative to you. Join us again in the future for future episodes updating folks on coronavirus in Living Branches. Thank you very much.