WHAT TO KNOW ABOUT THE COVID-19 PANDEMIC

Important takeaways from public health evidence.

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This article offers a look at five key COVID-19 trends from a health services research and health policy perspective.

RECOMMENDATIONS ARE EVOLVING

We are now in transition from staying home to opening safely. Of primary concern is understanding evolving public health and safety recommendations. From a public health perspective, we recognize past examples of outbreaks that came raging back after health measures were prematurely relaxed.[1] We must also pay attention to state and federal guidance on practice reactivation.

There is recommended federal guidance that governors must embrace.[2,3] For example, in Phase 1, each state must see a decrease in symptoms, infections, and hospital admissions for at least 2 weeks. These recommendations will continue to affect clinical decisions on how doctors of optometry can reengage.

Increased testing and contact tracing are needed to safely reopen while reducing risk of new outbreaks. A recent National Public Radio poll regarding preparation for contact tracing showed that only one state could meet estimated needs.[4] The vast majority of states do not currently have the capacity to meet needs for contact tracing—a historical pandemic public health action. At this time, social distancing remains the only effective countermeasure.[5]

A cost-effectiveness study by Bartsch et al found that if COVID-19 were to infect 80% of the US population, it would result in $654 billion in direct costs over the course of the pandemic.[6] If only 20% of the population is infected, there would still be 11 million hospitalizations and 1.6 million ventilators used, costing $164 billion.[6]

Even though the curve may be flattening in certain regions, case rates are still increasing. A study by Fisher et al found that measuring COVID-19 based on hospital referral regions is different from other types of federal data.[7] The study showed that every hospital referral region had at least 20 cases of the virus; 300 had more than 50 cases, and almost 300 had more than 100 cases. It's important that we stay current with strong science and local public health data to make informed decisions.

PRIMARY CARE IS TAKING A HIT

Primary care physicians, including primary *eye care* physicians, have been taking a huge patient care hit. In one study, visits to ambulatory practices declined by almost 60% through mid-March and remained low through mid-April.[8] Ophthalmology visits (optometry was not included) were down almost 80%. Recent data from the American Optometric Association (AOA) Health Policy Institute also found that 80% of doctors of optometry were providing emergent and urgent care during the pandemic, and three out of four doctors had personally taken a reduction in income.[9]

Another trend of note is that telemedicine has replaced only 30% of primary care.[8] Of major concern during the pandemic is maintenance of appropriate treatment for chronic conditions. While modifying care delivery, doctors of optometry must remain focused on best health outcomes. Advocacy from the AOA has included clinical resources and optometric parity with physician colleagues in relief legislation, including the Paycheck Protection Program.[10]

REACTIVATION AND DELIVERY OF CARE

Many organizations have generated best practices for reopening offices, but there is no tested formula. Thinking about patient care in terms of patient needs as symptomatic or asymptomatic is a great way to start a triage flow chart. If a patient is symptomatic, determine if his or her needs are emergent, urgent, semiurgent, or nonurgent. This will identify what care you are going to deliver and how (ie, in person or via telehealth). Many factors affect access to care. Doctor availability

is a *potential access* factor. When can you and your team be reached? Patient uptake of care is *realized access*. If a patient cannot access the internet, how can you best meet the standard of care?

Moving forward, when will the public view access to care as safe? It's not just what doctors are doing, it's also understanding what's happening in our communities. How will patients seek out care? When will they trust that it's safe to visit in person? What if a patient is symptomatic of COVID-19? What if a team member gets sick? There are webinars, resources, tools, and timely news on the AOA website (aoa.org/coronavirus) to help answer these questions.

THE FALLOUT

Professional Education

One of the earliest changes across all health care professions has involved delivery of didactic and clinical education. There are pros and cons when education is presented via distance means.[11] It is unknown how these changes will affect long-term outcomes.

Gender Disparity

One in three jobs held by women in the United States has been designated as essential during the pandemic.[12] Most of those women whose jobs were designated essential are likely nonwhite.[6,13] Women also tend to have a disproportionate burden of home care and child care.[6,13] Editors of academic journals have noticed that women are submitting fewer papers during the pandemic.[14] How will female academic accomplishments be evaluated during and after the COVID-19 pandemic? Awareness of existing and potential future disparity is critical.

Mental Health

Before the pandemic, there was growing concern and organizational focus on developing strategies to minimize doctor burnout. Staff burnout is also a factor, along with mental health challenges accompanying the pandemic. This is an area where additional strategies, research, and guidance are needed.

Patient Safety

The FDA relaxed guidance during the pandemic allowing eye doctors more leeway using certain medical devices and technologies. This also opened a door for unscrupulous companies and individuals for whom patient safety is not a priority. Standards of quality care must be maintained to prevent abuses to patient safety and ensure best health outcomes moving forward.

LIFE GOES ON

We need to remember that the world continues to turn. Before the pandemic hit, efforts to expand health insurance and prevent people from losing it were still front and center. Access to essential health care remains important, and political battles and regulatory issues are still with us.

For example, there is ongoing pushback in Arkansas by ophthalmology attempting to overturn optometric scope expansion. These issues will require us to remain active and vigilant.

OPPORTUNITY IN A CRISIS

The pandemic offers opportunities to reevaluate what doctors are doing. Do you want to modify the care you offer? Maybe add a specialty or redelegate how care is delivered in your practice? Now is a good time to consider change.

Optometric care is essential health care. Advocacy via the AOA, states, and fellow colleagues continues to focus on opportunities to further the value of optometric care to health and work. Doctors of optometry are engaged in COVID-19 testing and lead primary care delivery in our communities. Nearly 60% of the patients treated by optometrists during the pandemic would have otherwise sought care at emergency departments.[9] ■

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