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How Are DPMs Coping with the COVID-19 Crisis?

Our experts discuss patient care, safety, economic survival, staffing issues, and best practices.

BY MARC HASPEL, DPM

As this special roundtable was being developed, we knew at *PM* that we were facing the challenging task of needing to be timely, but at the same time we were well aware that the future remained uncertain—how much of our lives and our practices would be "back to normal" by the time your eyes were scanning these pages? We realized, however, that you would find this information essential in any case—whether, as you read this, the crisis is continuing with major force, or threatening a second appearance in the fall, or winding down—in which case you'll need to know the basics as "best practices" for an unwelcome (but possible) similar future event.

The COVID-19 pandemic has left (or is still creating) damage in its wake that now may take many months from which to recover. The task for podiatric physicians having to navigate the stormy waters of this unfortunate situation has been daunting, to say the least. An entire new set of practice management concerns have surfaced, including diminished revenue flow, varied employment issues, necessary patient safety compliance measures, and the emergence of telemedicine to treat patients unable to maintain their office appointments—not to mention how to deal with the challenges of returning to some form of normalcy in patient care, economic survival, and office management. Many doctors have turned to social media as a way of staying in touch with patients who were forced to stay at home during the public health crisis. Despite all these extraordinary obstacles, we are hoping that most podiatric practices will be able to persevere and now must begin the important process of returning to full capacity.

With that in mind, *Podiatry Management Magazine* has assembled a panel of well-known podiatric practitioners from across the country. Their practices range in size, location, and composition. Regardless, each has had to manage their practices through this most difficult of times. They reflected upon the strategies they used/are continuing to use for coping during the pandemic and offered recommendations as they look forward towards a hopefully healthy future.

Joining this panel:

Jeffrey Lehrman, DPM is a fellow of the American Society of Podiatric Surgeons. He is a certified professional coder and is a consultant to the Health Policy and Practice Department of the American Podiatric Medical Association.

Melissa Lockwood, DPM is the founder and owner of Heartland Foot and Ankle Associates in Bloomington, Illinois. She can often be heard as a nationally recognized speaker on practice management and podiatric medical topics.

Seth Rubenstein, DPM has been in private practice for thirty-five years. He has served on various committees in his local hospitals and has prior experience serving through the chairs of his local and state associations. He is currently president of the American Podiatric Medical Association.

Janet Simon, DPM began practicing in Albuquerque, New Mexico in 1991 and merged her practice into a multi-location practice in 2018. Her practice has developed special expertise in non-surgical care plans, diabetic and arthritic foot care, sports medicine, and footwear/orthotic/brace

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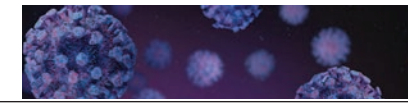

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treatments. Dr. Simon serves as the executive director of the New Mexico Podiatric Medical Association. She is active with the American Podiatric Medical and Public Health Associations serving on several committees and the executive board for APMAPAC.

Ben Weaver, DPM is a board-certified physician in podiatric orthopedics and primary podiatric medicine. He completed his Doctorate of Podiatric Medicine from the Ohio College of Podiatric Medicine in 2001, and his primary residency training at Veteran Affairs Hospital of Huntington, West Virginia. Dr. Weaver completed his certification for wound care, and is the only podiatric physician in Central Kansas to obtain this certification. He is a fellow of the American Professional Wound Care Association, and a Certified Wound Specialist.

Lowell Weil, Jr., DPM is the chief operating officer of the Weil Foot & Ankle Institute, a thirty podiatric physician and one hundred-fifty employee podiatric business covering twenty-one locations in Illinois, Wisconsin, and Indiana. He is also founder of Foot and Ankle Business Innovations (www.fabihub.com) that provides education to physicians looking to improve patient care while implementing proven business techniques.

PM: *How has the COVID-19 pandemic affected your practice, and what are/were the factors, such as its location and your practice style, that are/were influential?*

Rubenstein: I am a member of a single-specialty group practice called Foot and Ankle Specialists of the Mid-Atlantic. My office is in Reston, Virginia, a suburb of Washington, DC. We are on the campus of Reston Hospital Center and, as such, have the opportunity to observe the pandemic one patient at a time through hospital reports and proportional access restrictions at the facility as the case numbers grow.

Our patient volume began to decrease once my community had its first COVID-19. We noted a decrease of about twenty-five percent in week one, fifty percent in week two, and more than seventy-five percent in week three.

Simon: I practice in a multi-location podiatric group in an urban environment where twenty-five percent of our patients are traveling to one of our offices located greater than thirty minutes away. Perhaps five percent of patients are traveling even greater than one hour. Once public health emergency orders were promulgated, patients were risk-stratified. Those identified with higher risks, and not requiring immediate care, were rescheduled for three-four weeks and informed that if they identified problems, they were to contact the office that was to remain

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open. The patients identified as requiring in-person visits were contacted and triaged over the phone to assure they were not experiencing fevers, new onset cough, or other flu-like symptoms. Providers were directed to contact patients, who were in post-op recovery periods, fracture healing periods, or with active wounds to inform them of their options.

Patient census immediately decreased for all providers in my practice, and, after the first week, elective surgeries at the hospitals and surgery centers were slowed, then ordered discontinued. Our patients were informed our services were considered essential under the public health emergency orders and offices were to remain open, but with decreased hours.

Weil: Every person in our organization was affected in one way or another; each person's reaction was individual. We recognized from the outset that some would feel better staying at home and quarantine, while others would continue to provide patient care as best as possible. No one is more correct than the other.

We have one hundred eighty physicians and team members, so we had to manage a bigger group of people than some other practices. We have a centralized operations center that houses a lot of our people. Early on, we started taking people off site, and creating home/work environments for those who could work remotely like call center, revenue cycle, accounting, human resources, and marketing. We wanted to protect people and not have a single infected person cause a big organizational problem. We did this before there were any requirements to do so.

Our chief operating officer has been absolutely incredible in managing everything that we have gone through. Not once has she lost her cool or made a rash decision. During a time when chaos could have prevailed, she kept our company in the right mindset, and we weathered that early storm that seemed to impact other businesses more severely.

Lockwood: Our practice had seen a decline in patient volume of almost seventy-five percent. We remained open as teams to avoid cross contamination among our staff and physicians. We were seeing emergent patients in the office and had transitioned many follow-ups to telemedicine. We are very fortunate to be in a smaller community that had been complying well with the stay at home orders.

Lehrman: It had a tremendous impact on my practice. From early on, the Center For Disease Control (CDC) guidelines were to delay all elective visits and elective procedures. Anyone who did not follow those guidelines was selfish and irresponsible to their patients, their staff, and their community. We did not do what was best for business, but rather what was best for the world. This led to us seeing fewer than ten patients a day. The patients we did see had limb-threatening chronic wounds, infections, acute injuries, painful ingrown toenails, and other non-elective issues. In deciding whether or not a patient should be seen, we weighed the potential risks and the potential benefits for

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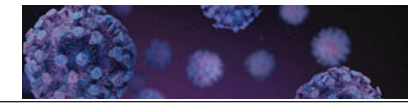

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all involved, and only had the patient come in if we felt the potential risks of them staying home and not receiving care outweighed the potential risks of them being out in the community.

Weaver: We were basically at half a schedule of patients.

Q ***PM:*** *Have you used telemedicine during the pandemic, and in any case, how do you see telemedicine playing a role in these types of crises?*

Simon: After the first week of declared emergency, clarification regarding telemedicine usage evolved, and we began identifying how to utilize telemedicine for patient care. Unfortunately, on the job learning was occurring with telemedicine options as opposed to being knowledgeable in protocols for usage with minimal stress. It's not only learning on the provider/staff part but also for our patients. The situation clearly illustrated that medicine has been a slow adopter of technological advances. Telemedicine is here to stay and may soon become the norm; however, podiatric care often requires procedures such as wound debridement and abscess incision and drainages that need real time interactions. The balance needed for successful patient care will take time and training; thus it will continue to evolve just as the usage of electronic health records demonstrated.

Rubenstein: Our leadership team quickly set up a telemedicine solution through Doxy.me. This platform offers HIPAA-compliant video-conferencing. Patient must initiate contacts through a normal appointment request. They were placed on our schedule and were provided a unique contact web address to reach the doctor. Obviously, we could not perform procedures, but we did offer some guidance for at home care and ordered prescriptions. We are considering expanding it to offer free diabetic foot screenings.

"The crisis also pushed me to learn all of the intricacies of telemedicine, including the coding, compliance, and documentation guidelines that accompany each of the options."—Lehrman

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Weil: Employing telehealth wasn't a simple switch to activate. Our information technology team spent many hours making the telehealth platform ready for prime time, as did the Operations and Call Center teams with workflow development. Our physicians and physical therapists started to engage in telehealth visits the week of March 30. This provided our patients a great opportunity to stay in touch with their providers and ensure some continuity of care, all while in a totally safe environment. The few patients with whom I did telehealth visits were appreciative of that option.

Lehrman: Yes, I used telemedicine. I found it to be a very helpful tool during the public health emergency. The crisis also pushed me to learn all of the intricacies of telemedicine, including the coding, compliance, and documentation guidelines that accompany each of the options. I think a lot of us may have been performing these services already when we returned patients' calls and responded to pictures patients sent us, and now we have learned that we can be billing for these services. I think the first thing that will come out of this time is that realization. As time goes by, more and more patients will demand non-face-to-services. We can meet, on-demand, so many of our needs using our phones now. People in greater numbers will look for options to meet their healthcare needs the same way. This event forced us to engage in telemedicine, and I would like to think our comfort level with telemedicine will be one of the positives that comes out of this.

"Typically, I found that business interruption insurance would only be covered if there was actual damage to property that prevents you from working, according to our carrier State Farm."—Weaver

Q ***PM:*** *What steps can you take to reduce the financial hit on your income (e.g., disaster loans, business interruption insurance, record-low interest rates, extended payment terms, shipping goods to patients, cost-cutting tips, etc.)?*

Lehrman: All of the above. The business interruption insurance proved to be incredibly useful for many during this public health emergency. To the degree that we were able, while remaining compliant with regulations, we continued to dispense certain items and supplies to patients throughout the emergency. We all saw many food take-out situations that allowed pick-ups to take place while adhering to all social distancing guidelines.

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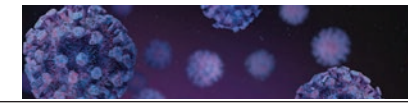

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We put something similar in place at our practice where patients called the office from the parking lot when they were purchasing products or picking something up, and we were able to make an exchange in a manner that kept all involved safe.

Weaver: Typically, I found that business interruption insurance would only be covered if there was actual damage to property that prevents you from working, according to our carrier State Farm. We were looking at delivering shoes to patients as we order a large quantity of diabetic shoes, and the guidelines for these had not been lifted. We were, however, running up against last seen dates. We watched to see what the government was going to pass regarding loans; there continue to be some interesting things in there for a small business that are beneficial. We also tried cutting costs in every area we could.

Rubenstein: First, I still recommend reviewing APMA's website at apma.org\covid19 for financial resources including a summary of federal programs and information about how to apply. There is also up-to-date information about the pandemic and frequently asked questions.

One's accountant should also be up-to-date on federal disaster relief programs such as SBA disaster loans and the recently passed CARES Act and SBA loan programs.

Some states have worked on legislative relief such as New Jersey's AB 3488, which would allow small businesses to apply for financial damages related to the coronavirus through their overhead/business interruption insurance.

Also, one should consider that keeping a practice afloat is one concern while keeping personal finances afloat is another. Interest rates now are very low. I recommend considering applying for a home equity line of credit if it one does not have one already. If one owns commercial real estate, one may consider refinancing the mortgage with the lender. This will reduce overhead now and save money over the long-term.

Lockwood: We had applied for and were approved for the Payroll Protection Program, requested advancement of funds from Medicare, and also reached out and applied for numerous grants. We were also lucky that our local bank agreed to interest-only payments for three months as we weathered this storm financially. Our staff had temporarily been given fewer hours as well. We also offered generous patient payment options to relieve the burden financially on our patients while encouraging them to bring their accounts current.

Weil: As soon as this started, we wanted to get into a positive cash position. While we had considerable cash on our balance sheet, we elected to draw our full line of credit. We felt that it was better to have the cash on hand and pay the interest rather than needing it later only to be turned down by the banks. Banks are notorious for not providing money when you most need it.

Our patient volume the first week of public health emergency orders in Illinois was at about twenty-five percent of normal expectations. That coupled with the cancellations of all elective surgeries required belt tightening of all aspects of the organization.

We spent that first week looking at how to conserve money to ensure the long-term success of the practice. We reached out to all vendors, landlords, utility companies, and banking institutions to ask for deferment or forgiveness in payments until which time that more revenue will be anticipated.

Nineteen of twenty-one of our landlords agreed to defer payments. Banking institutions deferred principle payments on loans. All vendors understood and professed a long-term relationship.

On Monday March 30, we applied for the Medicare stimulus prepayment program and less than a week later, we are already seeing some of that money come in.

Through our financial partner Stonehenge Partners, and due to the incredible work done by our accounting and finance team, we were able to apply for the CARES stimulus program the day it opened on Friday April 3. We anticipated upon qualification that the money would arrive in four to six weeks and provide needed cash to ensure that we maintained as many employees as possible for the foreseeable future.

I have heard of many companies which were not prepared or that their banks did not appropriately submit for this program and were currently scrambling to try to sort it out. We were extremely fortunate to have the team and support to be able to provide for our company.

Our accounting and finance team was busier than ever trying to conserve cash where they could. They created a very sophisticated thirteen-week cash flow analysis. This allowed us to take the daily revenue and patient visit data and place it into a model so that we could understand our business projects over the time that this crisis was expected to last. They also created a full 2020 projection with the same daily analysis and how that projects over the whole year using both a U-shaped and slow recovery models, so we could plan for best case and worst case scenarios. Things like this allowed our institute to stay ahead of this crisis and manage the business as best as possible with the day to day uncertainty that exists.

We had to reduce physician compensation to meet the decreasing patient volume and revenue associated with that. Despite that, our physicians still received a substantial amount of their draw twice/month. I believe that

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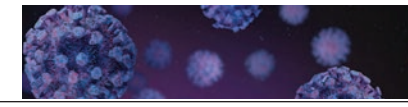
"We reached out to all vendors, landlords, utility companies, and banking institutions to ask for deferment or forgiveness in payments until which time that more revenue will be anticipated."—Weil



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no one was and remains immune to the financial implications of this crisis.

Q ***PM:*** *What are/were you doing regarding your staffing concerning hours, recent layoffs, new hires, accelerated stress levels?*

Simon: The stresses associated with COVID-19 were unprecedented. Our staff was informed immediately when public health orders for school and non-essential business closures were made that they could choose to stay at home on furlough and have the option to apply for unemployment. After the first week of the emergency order, we did have further staff furloughs. We informed all our staff that their job positions would be available to them once patient census was on the rise.

Lockwood: I believe communication was critical here. Our staff was aware of our progress with all the financial avenues noted above. We formulated a game plan for when this crisis was over and we would be inundated with patients. They knew their jobs were safe, their seniority within our practice secure, and their benefits intact, even if hours were less in the short term.

Lehrman: The APMA has extensive resources on self-care, well-being, mindfulness, and mental health. We shared these with staff and made sure everyone had the resources they needed to best help cope with what we all were going through.

Weaver: The bottom line was that seeing less patients, of course, would mean less revenue, but also less hours for the staff. We had been doing everything possible to keep things up and keep everyone going. Rotating staff with days off was just one example.

Weil: Due to our substantial decrease in patient volume, we were forced to consolidate physician schedules and flex employees to less hours. Scheduled hours could change daily. I know this was not easy as everyone has bills to pay and mouths to feed, but there were many businesses closing, unprecedented layoffs, and people applying for unemployment. Our institute had been working to manage the business to avoid layoffs and make sound business decisions to ensure its long-term well-being, while balancing the needs of our people.

We had strongly encouraged anyone who had their hours reduced to apply for unemployment. In addition to compensation available through their states, additional federal unemployment compensation of up to $600 per week may have also been available.

Even though we would be exempt from the new law based on being a healthcare provider, we elected to participate in the Emergency Sick Pay under FFCRA (Families First Coronavirus Response Act).

Our employee health benefits also included Disability Resource Services and Guidance Resources. This very valuable benefit allowed employees to have face to face sessions, unlimited telephonic counseling, and web-based services to help navigate the different emotional, time, and financial struggles that came with the crisis. This had been very helpful to our employees during the uncertain times.

Rubenstein: I think each practice must have made decisions based on its own situation and capabilities. Adjusting office hours and staff time to fit patient care requirements helped reduce some overhead. We tried to stagger patient appointments to minimize the number of people in our reception room throughout the day, as well as adjusted our support staff's schedule. The goal was to decrease peer-to-peer contact in the office.

Allowing some or all employees to apply for unemployment insurance, with the understanding that they would be hired back as soon as possible, would also have been a prudent strategy.

My situation is somewhat unique as our practice has a committed private equity partner with access to market funding. Our plan for the month of April was to keep our full-time employees on the payroll at full pay, whether they worked in the office four hours a week or forty. Associate doctors had the option of a guaranteed salary, based upon eighty percent past production structured as an advance, which will be gently repaid over time. We felt this would avoid the need to take out personal loans and provide income for set expenses such as mortgage payments.

"We requested patients use hand sanitizer at check-in and increased the disinfection frequency of office spaces."—Simon

Q ***PM:*** *What podiatric procedures, if any, have you prioritized, elective versus non-elective, for example, during/while recovering from the health crisis? How are you/were you balancing your patients' need for treatment vs. protecting them/you/other patients from the virus?*

Rubenstein: As small business owners, we had to walk the fine line between being responsible to minimize exposure to our patients, our staff, and ourselves, while still trying to operate our businesses. Doctors needed to consider their personal risk as well. Those in a high-risk population due to their age or medical history needed to seriously consider avoiding patient care at this time.

We were discouraging patients over age sixty from coming in for non-acute reasons. Otherwise, we still were treating patients with complaints of pain, injury, or infections, which for the most part is procedure-based.

Outpatient elective surgeries were essentially off the table. Non-elective surgical cases such as fractures and diabetic wounds were addressed, but might also require life-essential criteria with decisions made on a case-by-case basis at the local hospital.

In the office, we scheduled pa-

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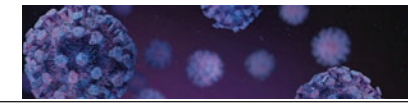

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tients in a fashion that did not produce overcrowding in the reception room. Each patient encounter was followed by meticulous cleaning of all surfaces, from patient exam chairs to door handles. We also practiced safe distancing, wearing gloves and washing hands regularly.

Simon: We reduced the seating available in our reception area whereby the six-foot distancing rule was followed and asked patients to reduce their family members/caregivers from coming into the office unless necessary for patient safety. We requested patients use hand sanitizer at check-in and increased the disinfection frequency of office spaces. The inclusion of telemedicine options, especially for our high-risk patients, was in place the second week of the emergency.

Lehrman: Throughout the crisis, we followed the CDC guidelines to delay all non-elective visits and procedures. We did keep limited hours for non-elective visits. These patients had limb-threatening chronic wounds, infections, acute injuries, painful ingrown toenails, and other non-elective issues. In deciding whether or not a patient should be seen, we weighed the potential risks and the potential benefits for all involved, and only had the patient come in if we felt the potential risks of their staying home and not getting care outweighed the potential risks of their being out in the community.

Lockwood: We were not performing any elective procedures. Only emergent pain and infections were being addressed during that time.

Weil: We put excellent protocols in place to continue to provide as much essential care as possible, while still being cognizant of social distancing and providing safe environments for our patients, team members, and physicians. We wanted to be available for the patients, who needed our care and, at the same time, not endanger themselves and others in receiving that care.

Initially, we thinned schedules of providers and eliminated what we thought of as non-essential care as directed by our governor. This was especially important in high risk groups. We had some pushback from our doctors who wanted to continue to treat anyone who desired treatment. After understanding what we were dealing with, all doctors gladly complied with guidelines. Patients quickly self-selected out of care as well, and patient volume reduced very quickly.

Many patients still wanted treatment and we left it up to the physician to decide which patients were appropriate to be cared for in person at this time. We did provide them daily updates that were considered current thoughts and trends since those seemed to be changing daily.

PM: *How are you using social media and other marketing efforts to communicate with patients, and what are your thoughts on using these vehicles to help restore your practice?*

Lehrman: Literature demonstrates the tremendous power of social media in educating and engaging one's community. Our practice used social media to post updates and to educate. As we come out of the worst of COVID-19 and things start to return to normal, we can still use social media to educate about our services and plan to re-integrate all of our patients. While social media is powerful, it cannot be relied upon alone. Using other communication tools is important as well.

"We embraced new social media avenues, such as YouTube, tiktok, and Instagram to further our message of #SafetyFirst #FeetSecond.."—Lockwood

We also implemented and followed CDC protocols. We quickly employed social distancing. We created a four-step screening process, which started with our call center representatives contacting all patients within twenty-four hours of their appointment to see if they had any symptoms. We posted CDC notifications outside our offices. Once a patient entered, screening questions were repeated, and then finally those questions were asked by medical assistants in the treatment room.

Patients were offered the opportunity to stay in their cars until a treatment room was ready and then called to come in. They would proceed right into a treatment room and avoid being around others.

We became even more diligent with our cleanliness and hand washing protocols.

We didn't know when this would begin to subside and we were completely committed to continue to provide the best environment for our patients, team members, and physicians so that as this crisis wanes, we would be back to being the best providers of foot and ankle care we can be.

Lockwood: We had been recording a weekly video updating our procedures and highlighting the ways we are protecting our patients. We put together a series of videos for social media that described ways patients can treat common issues at home with a call to action of more information available on our website. We embraced new social media avenues, such as YouTube, tiktok, and Instagram to further our message of #SafetyFirst #FeetSecond. Weekly emails were sent highlighting all of the above. We made phone calls to our patients who had to reschedule or cancel to check in on them.

Rubenstein: We have a very robust website and Facebook page. We also have automated patient reminder calls to cell phones and used this functionality to transmit notices such as availability for telemedicine.

Weaver: Likewise, we increased our social media presence since that was really the only type of marketing we could do during the crisis.

Weil: Our marketing team had

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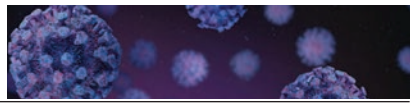

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created messaging to inform patients, referring physicians, urgent care facilities, and emergency rooms that we were available for urgent foot and ankle care needs. The goal was to reduce the burden on those front-line facilities that were inundated with COVID-19 patients while trying to direct some patient volume to our clinics.

We created informational videos on our website and posted them on social media about COVID-19, financial support that was available, and the availability of our physicians/clinics to care for urgent foot and ankle needs at our offices. We also emailed our regular patient newsletter, giving COVID-19 information as well as home foot health recommendations.

We tried creating patient facing webinars to further educate our patients on different foot and ankle conditions.

Our call center team was amazing dealing with the cancellations, rescheduling of appointments to ensure safe social distancing, and attempts to turn cancellations into telehealth and outreach calls. We did everything possible to continue to treat those who needed to be treated and were appropriate to safely visit our clinics.

"We already are keeping an eye on the next potential outbreak in the fall."—Rubinstein

Q ***PM:*** *What recommendations or preparations do you have going forward to prepare for the next potential pandemic and/or the potential outbreak of Covid-19 in the fall ?*

Simon: As a public health advocate, being prepared has always been on my radar. A pandemic was expected in the public health world, and over the last twenty-five years that I've been active in public health, the expected time for such an event was at any moment. Unfortunately, our priorities have trended away from preparedness, and many communities do not have the basic infrastructure in place to address what to do. Funding of public health services has trended downward while the frequency of emergencies has increased. This lack of preparedness has repeatedly been demonstrated over the last several years as responses to environmental emergencies have ramped up. In my opinion, it came as no surprise that COVID–19 responses were piecemealed throughout our country for that is how the system had continued to be prior, even as public health professionals had called for increased international and interstate cooperation.

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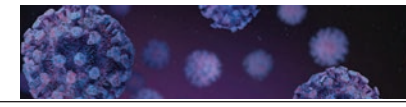

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On a more micro-level, I believe having a current business disaster plan in place is not just meant to be a required file in one's office, but is dynamic and should be consistently reviewed by all practice members.

Sustainable medicine has become a topic of interest for me, and this has obviously proved important considering this recent emergency. Resources are not indefinite, especially in an emergency. Developing ways for reusing equipment and personal protective equipment is a priority. The move to disposables as the standard and away from reusable supplies/equipment has driven the system into one of deficits that increase the risks for everyone in our communities. I believe COVID-19 will force us to look at the current intersections of healthcare, economics, and the environment in enlightened ways whereby the term sustainable is a discussed priority.

Weil: There is so much to be learned from a crisis like this one. The first recommendation I have is to invest in one's team. I see a lot of podiatric medical practices which want to skimp on people. One's business will never reach higher levels unless there are the right people in place to support it. It's really critical to have positive leadership. It's easy to bury one's head in the sand during difficult times, but one's team is looking for leadership and guidance. Therefore, it's important to step up and lead confidently

Moreover, this crisis truly demonstrated the importance of practice protocols. Time spent creating protocols is key to a smoothly running business. It allows the business to overcome all obstacles, big and small.

Lockwood: Personally, I think I will need a bigger war chest. We had approximately four weeks of working capital, which we burned through very quickly. Also, I recommend meditation and focusing on the present rather than wasting time worrying about the future unknowns.

Rubenstein: I agree that shoring up one's personal finances to ensure availability of cash liquidity for three to six months of expenses would be prudent. So would monitoring how well one's contractors perform, including everyone from the cleaning crew to medical supply sources.

Our leadership team is assessing what supplies were critical and in need, with an eye toward ensuring access to such supplies when needed in the future. We already are keeping an eye on the next potential outbreak in the fall. **PM**

Dr. Haspel is senior editor of this magazine and past-president of the New Jersey Podiatric Medical Society. He is a member of the American Academy of Podiatric Practice Management.