Primary Care's Role in Responding to COVID-19

WEDNESDAY, APRIL 15, 2020 | 2:00–3:00 ET

agenda

1. **PCC Announcements & Introductions** — *Beverley Johnson*
2. **American College of Physicians** — *Darilyn Moyer*
3. **University of Washington School of Medicine** — *Michael Tuggy*
4. **Doctor on Demand** — *Ian Tong*
5. **Weitzman Institute at Community Health Center Inc.** — *April Joy Damian*
6. **Participant Q&A**

Welcome & Updates

Become a Member!

Save the Date: PCC 2020 Annual Conference

November 5 & 6

PCC/Green Center's Weekly Survey of Primary Care Clinicians

Speaker Introductions

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Primary Care & COVID-19

April 1, 2020
Primary Care & COVID-19: Week 3 Survey

March 26, 2020
Primary Care & COVID-19: Week 2 Survey

March 19, 2020
Primary Care & COVID-19: Week 1 Survey

Are you a physician, nurse practitioner, or PA working in primary care?

Help PCC and the Larry A. Green Center track how your practice is responding to the COVID-19 outbreak by completing the weekly survey.

The next survey will open on April 17.

COVID-19 Updates

April 15, 2020 | NPR
How COVID-19 Patients Are Affected By Health And Other Disparities

April 10, 2020 | Los Angeles Times
Coronavirus already changing medical care in the U.S.

April 9, 2020 | Primary Care Collaborative
Primary Care & COVID-19: Week 4 Survey

April 1, 2020 | Primary Care Collaborative
Primary Care & COVID-19: Week 3 Survey

March 27, 2020 | PCPCC Press Release
Survey of primary care clinicians shows increasing pressures on practices in their response to coronavirus

Primary Care & COVID-19

ThePCC.org/COVID

- 72% of surveyed clinicians say that they have **patients who are unable to access telehealth** due to no computer/internet.
- Patient **mental health** is being recognized as a critical need. 54% report that COVID-19 has led to increased numbers of patients with mental or emotional health needs.
- 58% report the use of **used and homemade PPE** at their practice.
- About half of respondents report that COVID-19 is having a **“severe” impact** on their practice.

Today's Speakers

MODERATOR: Beverley H. Johnson

President & CEO, Institute for Patient and Family-Centered Care

Darilyn V. Moyer, MD, FACP, FRCP, FIDSA

Executive Vice President & Chief Executive Officer, American College of Physicians

Michael Tuggy, MD

Clinical Professor, University of Washington School of Medicine

Ian Tong, MD

Chief Medical Officer, Doctor on Demand

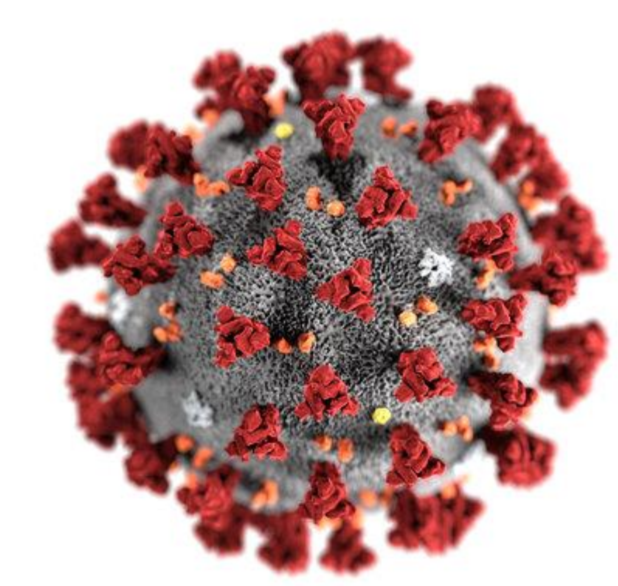
April Joy Damian, PhD, MSc

Associate Director, Weitzman Institute at Community Health Center

Primary Care In the Time Of COVID…

Darilyn V. Moyer MD, FACP, FIDSA, FRCP

EVP/CEO, American College of Physicians



COVID 19-Perfect Pandemic Prescription

- Novel pathogen with respiratory transmission
- 80 % infected are asymptomatic
- Long incubation period of ~ 5 days with long interval between cases (serial interval)
- High reproductive factor
- Prolonged shedding time after clinical resolution
- Effective fomite transmission
- Transmission via airborne and oral-fecal
- Lack of sentinel surveillance
- Lack of coordination of initial response at any level
- Lack of readily available testing
- Personal Protective Equipment shortages and Infection Control inadequacies
- No effective treatment or vaccine

Never Were The Principles Of PCC More Relevant…

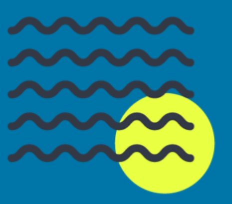
The Shared Principles of Primary Care

PERSON-CENTERED

TEAM-BASED & COLLABORATIVE

COMPREHENSIVE & EQUITABLE

COORDINATED & INTEGRATED



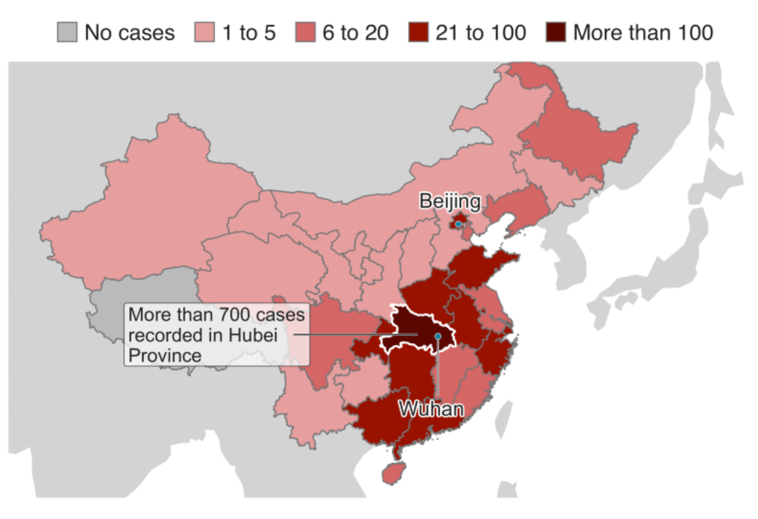
CONTINUOUS

ACCESSIBLE

HIGH-VALUE

Evolution of An Epidemic And Pandemic

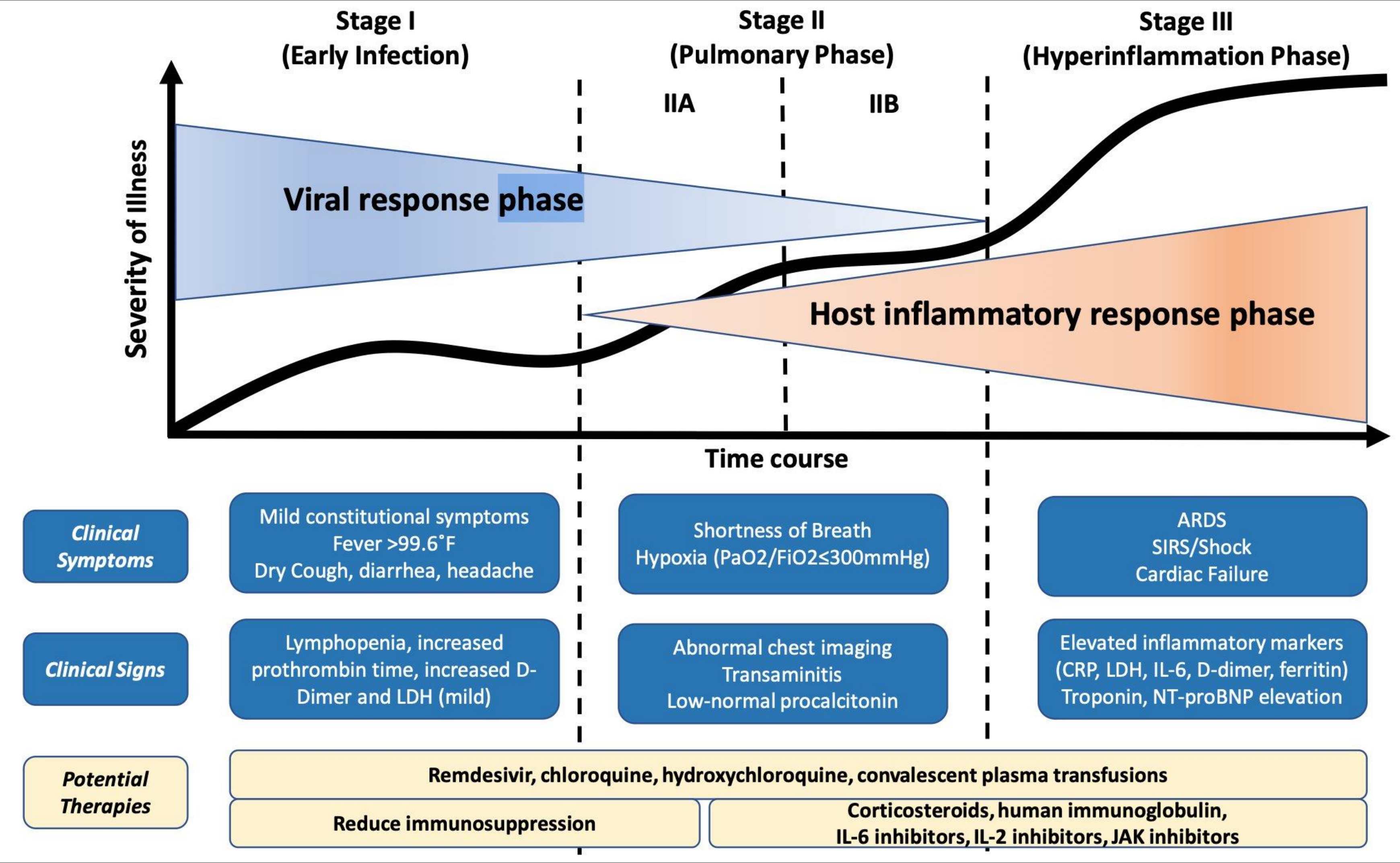
More than 1,000 cases confirmed in China



Source: China National Health Commission, BBC Research, 25 Jan

BBC

Source: Johns Hopkins CSSE


Stage I
(Early Infection)
Stage II
(Pulmonary Phase)
Stage III
(Hyperinflammation Phase)
IIA
IIB
Severity of Illness
Viral response phase
Host inflammatory response phase
Time course
Clinical Symptoms
Mild constitutional symptoms
Fever >99.6˚F
Dry Cough, diarrhea, headache
Shortness of Breath
Hypoxia (PaO2/FiO2≤300mmHg)
ARDS
SIRS/Shock
Cardiac Failure
Clinical Signs
Lymphopenia, increased prothrombin time, increased D-Dimer and LDH (mild)
Abnormal chest imaging
Transaminitis
Low-normal procalcitonin
Elevated inflammatory markers
(CRP, LDH, IL-6, D-dimer, ferritin)
Troponin, NT-proBNP elevation
Potential Therapies
Remdesivir, chloroquine, hydroxychloroquine, convalescent plasma transfusions
Reduce immunosuppression
Corticosteroids, human immunoglobulin,
IL-6 inhibitors, IL-2 inhibitors, JAK inhibitors

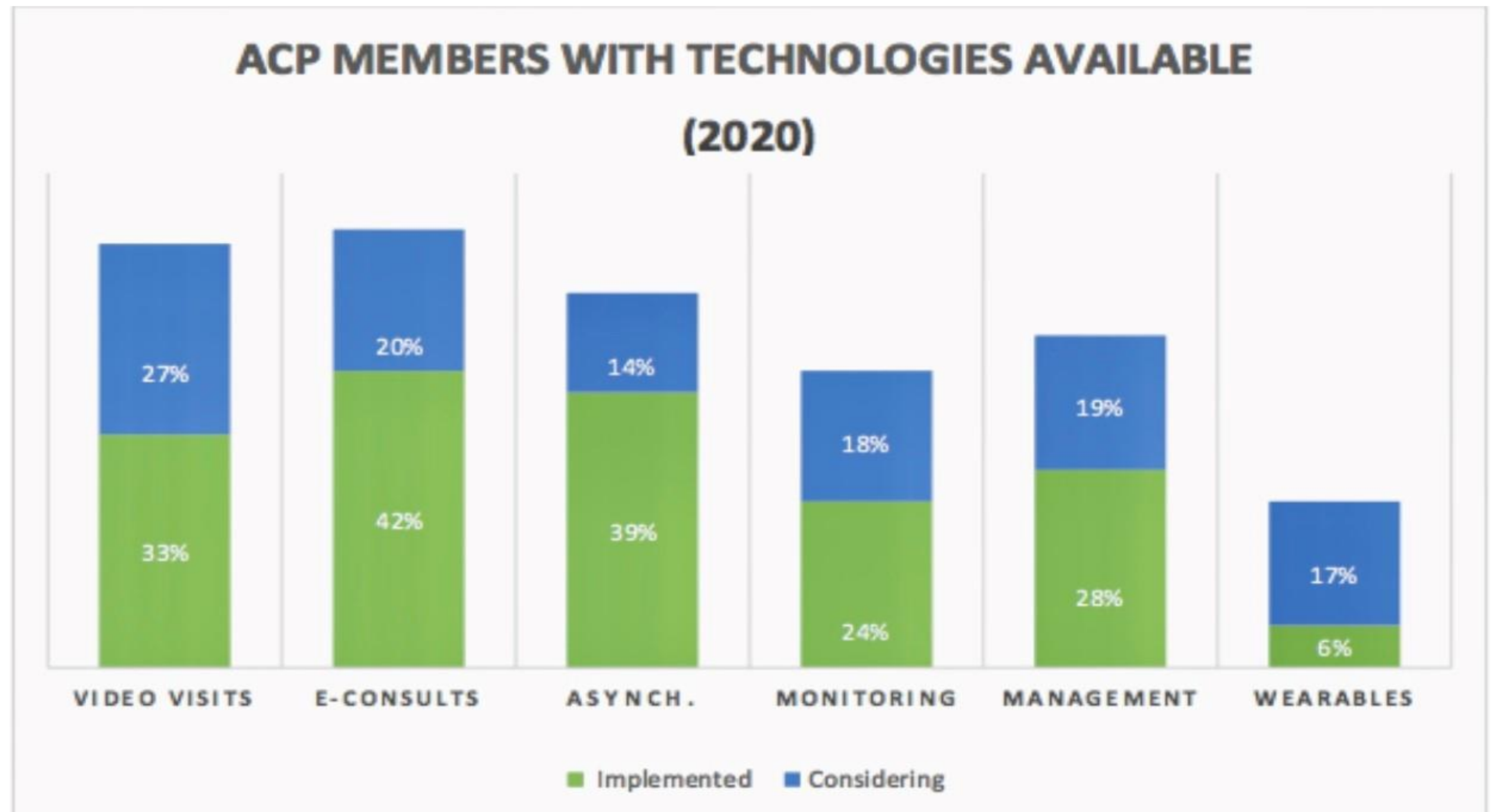
COVID-19 Did in 20 Days What Didn't Happen In 20 Years…And Revealed More Chasms In Our Healthcare System

Rapid responses by practitioners in the primary care space to transition their practices to optimize safe patient care and minimize risk to patients and their practice colleagues, and keep patients out of the ED and hospital

Issues of practice transformation, patient care and triage algorithms, digital readiness, connectivity/interconnectivity, protected health information, practice revenue/viability, lack of PPE and access to COVID-19 testing, tsunami of data, and changing regulations on documentation and billing and coding from local and national authorities

Lack of ready and safe testing availability, and coordination amongst local, regional, state, and national healthcare organizations and public health authorities result in unprecedented coordination amongst stakeholders

Pre-COVID: Jan. 2020 American College of Physicians Survey...



Top Line Take Homes From ACP Telehealth Survey 1/20

~ 2000 IM and IM Subspecialty members aged 65 years and younger

231 respondents- 50 % GIM specialist, 25% each hospitalists and IM Subspecialists

Use of video visits, remote monitoring, and remote management have all grown significantly over the past year

Hospitalists using video visits and e-consults at more than twice the rate as subspecialists

GIM specialists and hospitalists were most likely to be using asynchronous evaluation of data/images

Where technologies were available, remote monitoring and remote care management were both used significantly more often in rural practices

QUICK COVID-19 PRIMARY CARE SURVEY

SERIES 4 FIELDED APRIL 3-6, 2020

This is the fourth weekly national survey of frontline primary care clinicians' experience with COVID-19.

Four weeks in, 4 out of 5 primary care practices continue to experience sustained high levels of stress. This new normal includes persistent lack of personal protective equipment (58%) and tests (>50%), and nearly half of practices have clinical care team members out sick/quarantined. At the same time, practices (54%) are reporting an increase in patient mental and emotional health needs, patient challenges with implementing virtual care platforms (72%), and persistent financial uncertainties, with close to 60% not sure the majority of care they are provided is reimbursable.

More Specific Main Findings

- 29% of clinicians report no capacity for COVID-19 testing and 39% have only limited capacity
- Outages due to illness/quarantine reported for clinicians (48%), nursing staff (50%), and front desk (34%)
- 58% lack PPE; an overlapping but separate group of 58% rely on used and homemade PPE
- 90% of practices are limiting well and chronic care visits
- 40% of practices are prioritizing redeploy of clinicians within the health system

Virtual Health (Telehealth) Findings

- Full scale use of virtual platforms is limited: 23% rely on majority use of video, 5% on e-visits, and 6% on patient portal, compared with 40% conducting majority visits by phone
- 30% of practices report <u>no</u> use of video visits, 60% <u>no</u> use of e-visits, and 32% are <u>not</u> using patient portals

Primary care practices prioritize (as high or moderate) work that is largely unpaid, underpaid or delayed

- 86% of practices prioritize virtual triage and refer of potential COVID-19 patients (63% as high)
- 76% of practices prioritize calling patients at home for check in and monitoring (37% as high)
  - This rate is 43% (high) for majority Medicaid patients; 44% (high) for community health practices
- 59% are <u>not</u> scheduling preventive care; 51% are <u>not</u> scheduling well child care although 2/3rds prioritize

Top Line Take Homes From and ThePCC.org/COVID

3/20 Multistakeholder analysis of 138K Family Medicine physicians, whose practices supported 1.8 Million jobs

750 counties had ratios of population to family physicians > 3500:1

Using constant losses across time period 2/20-6/30/20, 58K (40%) fewer family physicians working in their practices with ~ 784K job losses

www.thepcc.org/covid

Survey Results Helping to Inform Primary Care Policy Recommendations

Policy Recommendations –

Required is a transparent, coordinated national effort to assure rapid and equitable distribution of testing and PPE for frontline practices.

Payers must urgently implement capitation/global payment to allow practices the ability to stay open, pay staff, and choose patient visit types based on need, and not on reimbursement levels.

Virtual telehealth/telephonic visits under commercial/Medicaid plans should be reimbursed at the same rate as face-to-face visits to meet patient needs, keep people out of the hospital, and protect healthcare staff.

ACP’s COVID-19 Resources- www.acponline.org

TELEHEALTH CODING & PAYER COVERAGE for PROVIDERS

PAYER	FACE-TO-FACE AUDIO VISUAL VISITS	TELEPHONE COMMUNICATION	PORTAL COMMUNICATION
Medicare Part B	*99211-99215-E/M established patient *99201-99205-E/M New Patient *99495/99496-TCM *G0438/G0439-AWV *G0442-alcohol screen *G0444-depression screen *99497-ACP *CMS lifts restrictions on telehealth to allow patients to be a home during audiovisual visit	*G2012-E/M via telephone; 5-10 min *established patient *provider discusses new or established medical problem with patient *medical problem cannot be related to visit 7 days prior *cannot lead to a visit within 24 hrs or soonest available *patient must verbally consent and consent is documented in record *no specific documentation requirements for discussion *record needs to show duration of call *patient not required to initiate call *patient has cost sharing and no frequency limitations	*99421-digital E/M; 5-10 min *99422-digital E/M; 11-22 min *99423-digital E/M 21+ min *established patient *provider responds to patient portal question and reviews record/data pertinent for assessment *medical problem cannot be related to visit 7 days prior or within global period of procedure *time is added during 7 day period and record needs to show total time *patient must verbally consent and consent is documented in record *no specific documentation requirements for E/M *patient required to initiate service *patient has cost sharing and no frequency limitations *Cannot bill on same day as any office visit *Cannot bill if same communication included as part of TCM 99495/99496
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Medicaid	*99211-99215-E/M established patient *99201-99205-E/M New Patient *99495/99496-TCM *Plans cover if patient at home *UHC Community covers only until 4-30-2020	*99441-E/M via telephone; 5-10 min *99442-E/M via telephone; 11-20 min *99443-E/M via telephone; 21-30 min *established patient *provider discusses new or established medical problem with patient *medical problem cannot be related to visit 7 days prior or within global period of procedure *cannot lead to a visit within 24 hrs or soonest available *no specific documentation requirements for discussion *record needs to show duration of call *patient required to initiate call *patient has cost sharing and no frequency limitations	*99421-digital E/M; 5-10 min *99422-digital E/M; 11-22 min *99423-digital E/M 21+ min *established patient *provider responds to patient portal question and reviews record/data pertinent for assessment *medical problem cannot be related to visit 7 days prior or within global period of procedure *time is added during 7 day period and record needs to show total time *patient must verbally consent and consent is documented in record *no specific documentation requirements for E/M *patient required to initiate service *patient has cost sharing and no frequency limitations *Cannot bill on same day as any office visit *Cannot bill if same communication included as part of TCM 99495/99496
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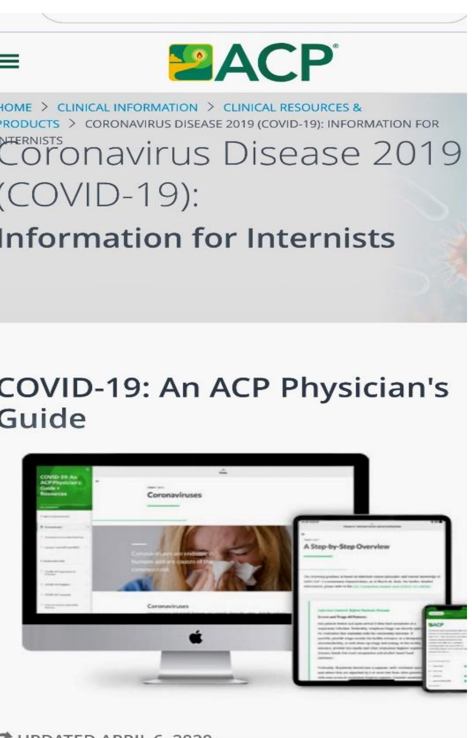
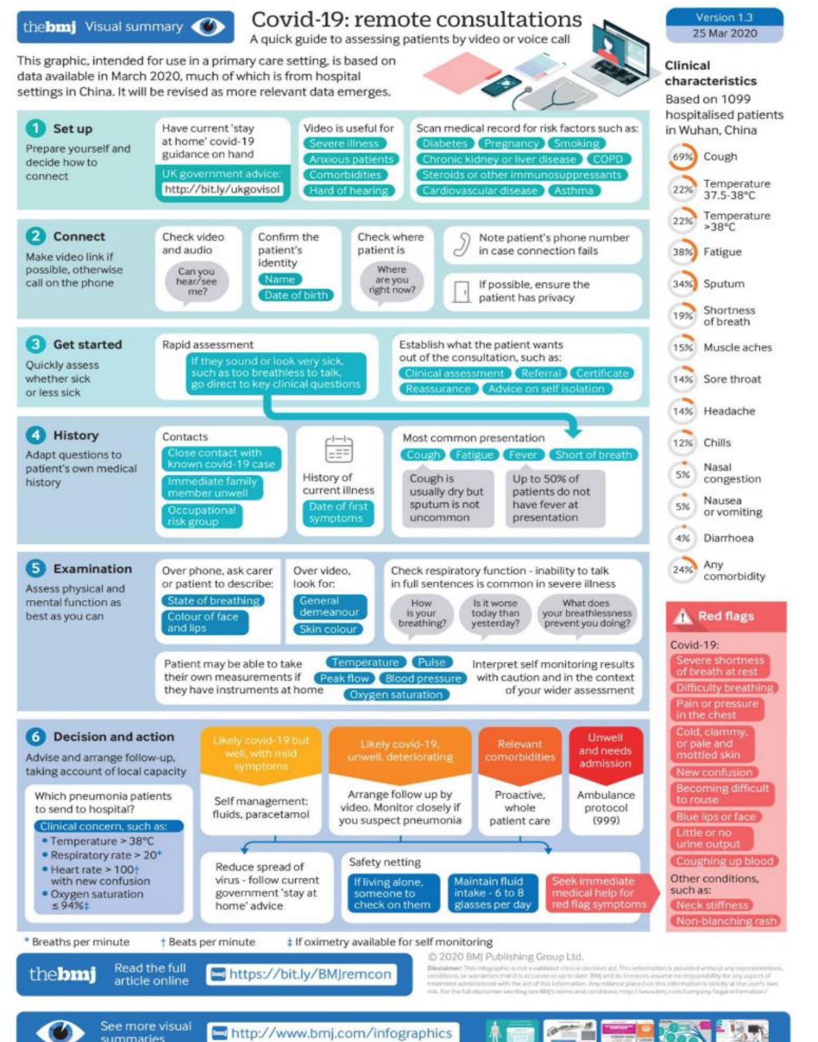


Rapid Transitions, Like Health Care, Are….

COMPLICATED!



thebmj Visual summary
Covid-19: remote consultations
A quick guide to assessing patients by video or voice call
Version 1.3
25 Mar 2020
This graphic, intended for use in a primary care setting, is based on data available in March 2020, much of which is from hospital settings in China. It will be revised as more relevant data emerges.
1 Set up
Prepare yourself and decide how to connect
Have current 'stay at home' covid-19 guidance on hand
UK government advice: http://bit.ly/ukgovisol
Video is useful for
Severe illness
Anxious patients
Comorbidities
Hard of hearing
Scan medical record for risk factors such as:
Diabetes
Pregnancy
Smoking
Chronic kidney or liver disease
COPD
Steroids or other immunosuppressants
Cardiovascular disease
Asthma
2 Connect
Make video link if possible, otherwise call on the phone
Check video and audio
Can you hear/see me?
Confirm the patient's identity
Name
Date of birth
Check where patient is
Where are you right now?
Note patient's phone number in case connection fails
If possible, ensure the patient has privacy
3 Get started
Quickly assess whether sick or less sick
Rapid assessment
If they sound or look very sick, such as too breathless to talk, go direct to key clinical questions
Establish what the patient wants out of the consultation, such as:
Clinical assessment
Referral
Certificate
Reassurance
Advice on self isolation
4 History
Adapt questions to patient's own medical history
Contacts
Close contact with known covid-19 case
Immediate family member unwell
Occupational risk group
History of current illness
Date of first symptoms
Most common presentation
Cough
Fatigue
Fever
Short of breath
Cough is usually dry but sputum is not uncommon
Up to 50% of patients do not have fever at presentation
5 Examination
Assess physical and mental function as best as you can
Over phone, ask carer or patient to describe:
State of breathing
Colour of face and lips
Over video, look for:
General demeanour
Skin colour
Check respiratory function - inability to talk in full sentences is common in severe illness
How is your breathing?
Is it worse today than yesterday?
What does your breathlessness prevent you doing?
Patient may be able to take their own measurements if they have instruments at home
Temperature
Pulse
Peak flow
Blood pressure
Oxygen saturation
Interpret self monitoring results with caution and in the context of your wider assessment
6 Decision and action
Advise and arrange follow-up, taking account of local capacity
Which pneumonia patients to send to hospital?
Clinical concern, such as:
• Temperature > 38°C
• Respiratory rate > 20*
• Heart rate > 100† with new confusion
• Oxygen saturation ≤ 94%‡
Likely covid-19 but well, with mild symptoms
Self management: fluids, paracetamol
Likely covid-19, unwell, deteriorating
Arrange follow up by video. Monitor closely if you suspect pneumonia
Relevant comorbidities
Proactive, whole patient care
Unwell and needs admission
Ambulance protocol (999)
Reduce spread of virus - follow current government 'stay at home' advice
Safety netting
If living alone, someone to check on them
Maintain fluid intake - 6 to 8 glasses per day
Seek immediate medical help for red flag symptoms
* Breaths per minute
† Beats per minute
‡ If oximetry available for self monitoring
Clinical characteristics
Based on 1099 hospitalised patients in Wuhan, China
69% Cough
22% Temperature 37.5-38°C
22% Temperature >38°C
38% Fatigue
34% Sputum
19% Shortness of breath
15% Muscle aches
14% Sore throat
14% Headache
12% Chills
5% Nasal congestion
5% Nausea or vomiting
4% Diarrhoea
24% Any comorbidity
Red flags
Covid-19:
Severe shortness of breath at rest
Difficulty breathing
Pain or pressure in the chest
Cold, clammy, or pale and mottled skin
New confusion
Becoming difficult to rouse
Blue lips or face
Little or no urine output
Coughing up blood
Other conditions, such as:
Neck stiffness
Non-blanching rash
thebmj
Read the full article online
https://bit.ly/BMJremcon
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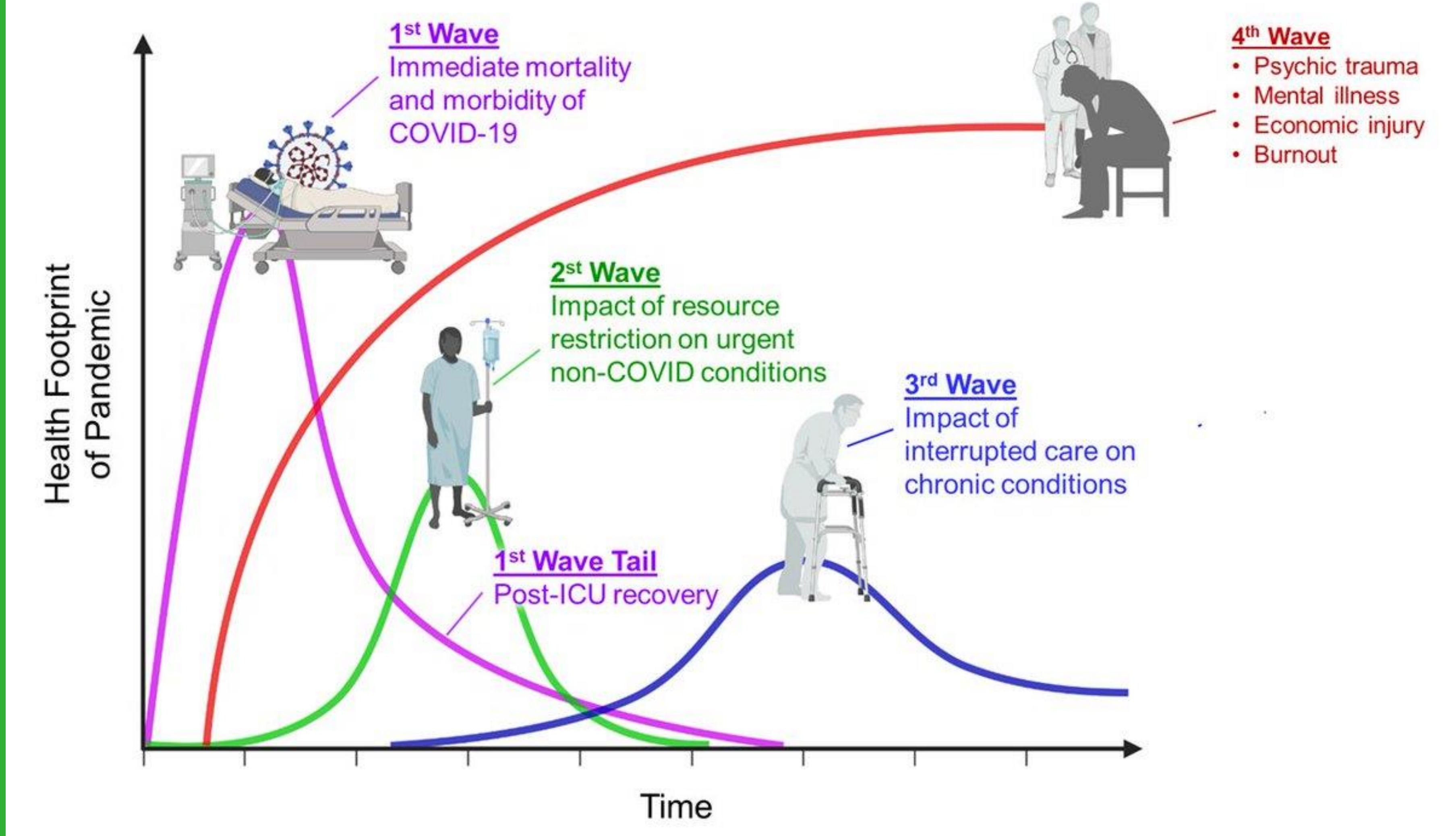
See more visual summaries
http://www.bmj.com/infographics


1st Wave
Immediate mortality and morbidity of COVID-19
4th Wave
• Psychic trauma
• Mental illness
• Economic injury
• Burnout
2nd Wave
Impact of resource restriction on urgent non-COVID conditions
3rd Wave
Impact of interrupted care on chronic conditions
1st Wave Tail
Post-ICU recovery
Health Footprint of Pandemic
Time

Better Is Possible: The American College of Physicians Vision for the U.S. Health Care System

Better Is Possible: The American College of Physicians Vision for the U.S. Health Care System, published as a supplement in *Annals of Internal Medicine,* offers an interconnected, holistic, and comprehensive plan to remove obstacles to care that undermine the patient-physician relationship and harm our patients' health.

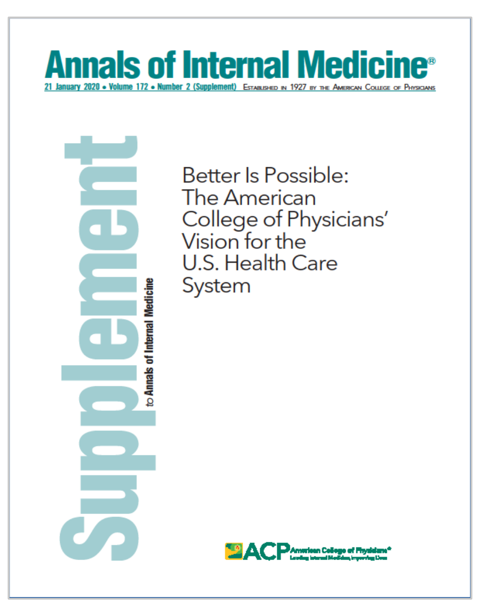
Four papers are included in the supplement:

A Call to Action from ACP

Coverage and Cost of Care

Reducing Barriers to Care and Addressing Social Determinants of Health

Health Care Delivery and Payment System Reform



Annals of Internal Medicine

Intersecting U.S. Epidemics: COVID-19 and Lack of Health Insurance

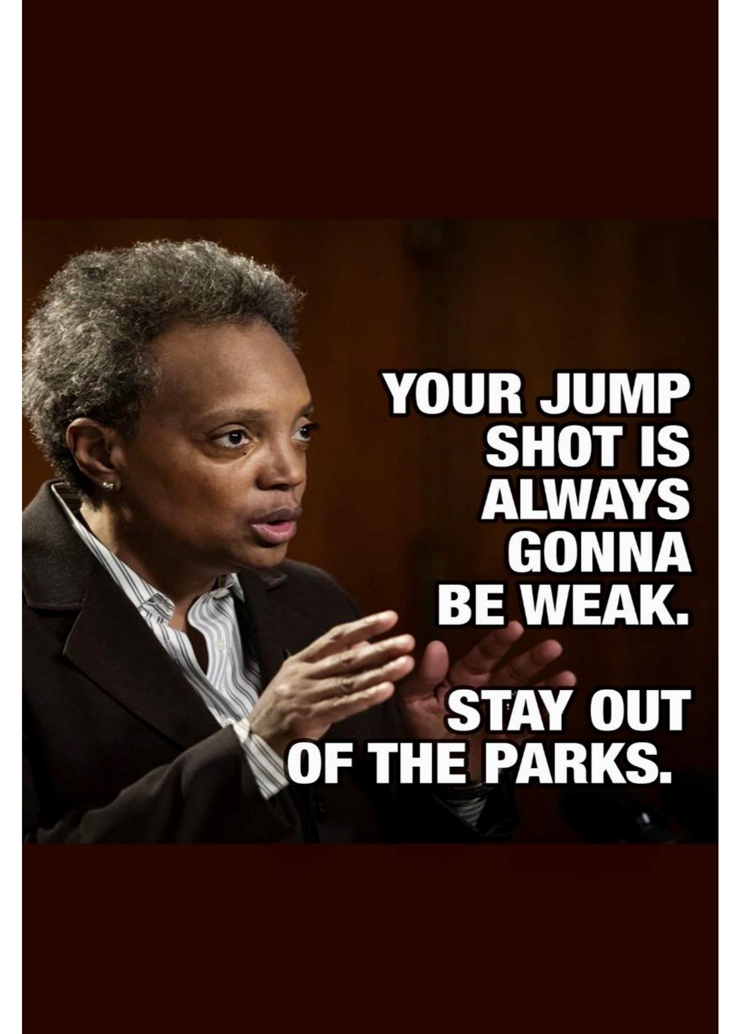
Steffie Woolhandler, MD, MPH, and David U. Himmelstein, MD

During the final week of March 2020, the U.S. Department of Labor reported that a record number of workers–6.648 million–filed new claims for unemployment benefits. That beat the previous record of 3.307 million filings, which was set the week before, bringing the 2-week total to 9.955 million. This is just the beginning of the surge in joblessness due to the coronavirus disease 2019 (COVID-19) pandemic. A Federal Reserve Bank economist estimated that the ranks of unemployed persons will swell by 47.05 million by the end of June (1).

For many, job loss will carry the added sting of losing health insurance. Congress has moved to cover severe acute respiratory syndrome coronavirus 2 testing for uninsured persons, but did not include provisions to cover treatment of COVID-19 (or other illnesses). The

Our projections are based on differences in cov age rates for employed and unemployed persons 2019, but there is little reason to believe that the p dicament of unemployed workers has improved sir then. Although many who lose their jobs are likely to eligible for Medicaid or subsidized Affordable Care coverage, and some will purchase continuing covera under COBRA (Consolidated Omnibus Budget Rec ciliation Act), the same was true in 2019. Indeed, t situation may be worse today because some laid- workers probably gained coverage through an e ployed spouse in 2019, an option less likely to be av able in the face of the impending massive layoffs.

URGENT POLICY NEEDS AND LONGER-TERM


YOUR JUMP
SHOT IS
ALWAYS
GONNA
BE WEAK.
STAY OUT
OF THE PARKS.

Thank you . . .

…for your continued support of ACP and your commitment to internal medicine.

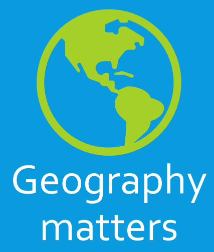
COVID-19 IMPACT ON RURAL PRACTICE

Michael Tuggy, MD

Physician Manager, Confluence Health

Winthrop, WA

MAJOR CHALLENGES



Geography matters

Testing

New Appointments: Telehealth and Telephone Visits

Staff safety and workforce integrity

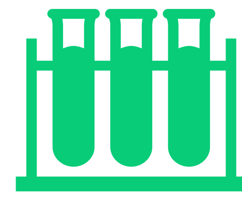
Community relations: Culture of suspicion/Rumor Mill

Payment model

GEOGRAPHY AND HEALTH CARE

- Travel time to ED > 1 hour
- Travel time to hospital with ventilator capacity – 2 hours
- Limited access – 2 clinics (FQHC and Private) within a 50-mile radius
  - Small clinics with limited staff – 2-3 FTE of providers at each site
- Urgent care access – we are it in our part of the county
- For patient safety, limited visits to patients with no URI symptoms of any kind

TESTING FOR COVID-19



- Testing on patients only with symptoms – fever, cough, shortness of breath
- Testing done outdoors and batched into one time period to use only one PPE set
- PPE tagged and bagged for the next week
- Results – up to 10 days to get results back for the first 2 weeks, then < 3 days

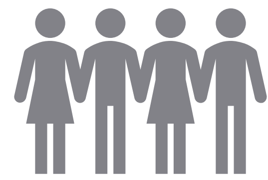
APPOINTMENT CHANGES

- No routine appointments (annual exams, AWE, non-urgent follow-ups)
- Continued to do same day urgent visits
- Sick visits – if possible viral infection, patient's seen outside on back porch or in "dirty room"
- Procedures – cancer excisions, implantable birth control
- Acute injury visits

TELEHEALTH AND TELEPHONE VISIT

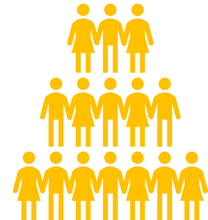
- Most patients did not have the tech skills to reliably connect with video
- More hassle but billing was 4-fold of doing phone visits
- Exactly the same care is delivered 90%+ of the time with or without video
- Phone visits – easy but $15 reimbursement is a practice killer
- Patients very pleased with these visits
- How will be transition back to FTF visits?

WORKFORCE INTEGRITY

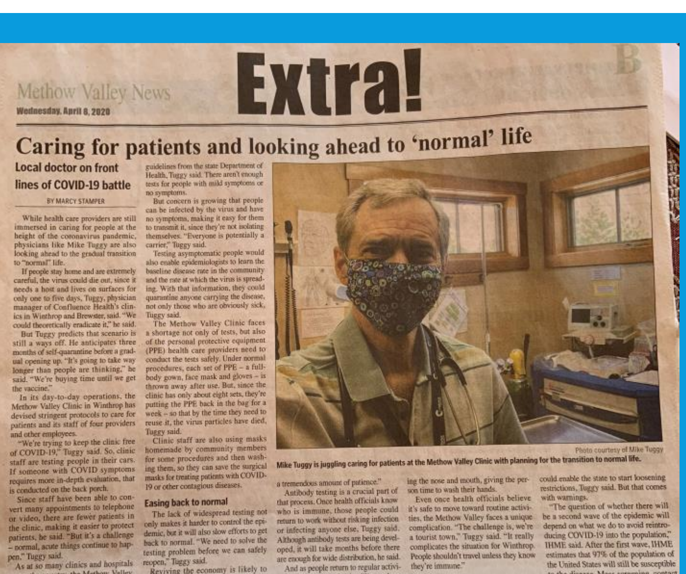


- Small clinic team, distancing is impossible
- If one person developed COVID, the clinic team would be placed on self-quarantine for 14 days due to our exposure
- No urgent care for our patients for 2 weeks would be highly problematic
- Starting using masks, gloves 2 weeks earlier than the CDC guidelines
- No infections to date
- Had to furlough some staff due to low volumes

WORKING WITH OUR COMMUNITY



- Provided weekly updates to community bulletin board online
- Many conspiracy threads by fringe users
- Rumors of our positive cases were more rapid than DOH notifications
- Just the facts – radio, newspaper and bulletin board posts
  - Dispelling false rumors, treatments, etc.
  - Suspicions of government and health system



Methow Valley News

Wednesday, April 8, 2020

Extra!

Caring for patients and looking ahead to 'normal' life

Local doctor on front lines of COVID-19 battle

BY MARCY STAMPER

While health care providers are still immersed in caring for people at the height of the coronavirus pandemic, physicians like Mike Tuggy are also looking ahead to the gradual transition to "normal" life.

If people stay home and are extremely careful, the virus could die out, since it needs a host and lives on surfaces for only one to five days, Tuggy, physician manager of Confluence Health's clinics in Winthrop and Brewster, said. "We could theoretically eradicate it," he said.

But Tuggy predicts that scenario is still a ways off. He anticipates three months of self-quarantine before a gradual opening up. "It's going to take way longer than people are thinking," he said. "We're buying time until we get the vaccine."

In its day-to-day operations, the Methow Valley Clinic in Winthrop has devised stringent protocols to care for patients and its staff of four providers and other employees.

"We're trying to keep the clinic free of COVID-19," Tuggy said. So, clinic staff are testing people in their cars. If someone with COVID symptoms requires more in-depth evaluation, that is conducted on the back porch.

Since staff have been able to convert many appointments to telephone or video, there are fewer patients in the clinic, making it easier to protect patients, he said. "But it's a challenge – normal, acute things continue to happen," Tuggy said.

As at so many clinics and hospitals across the country, the Methow Valley Clinic is hobbled by a shortage of coronavirus tests, and by the long turnaround time for results. The clinic had 23 test kits left as of April 7. Results have been taking from three to 10 days, Tuggy said.

"We should be testing a lot of people, but we can only test people with fever, cough and shortness of breath – the

guidelines from the state Department of Health, Tuggy said. There aren't enough tests for people with mild symptoms or no symptoms.

But concern is growing that people can be infected by the virus and have no symptoms, making it easy for them to transmit it, since they're not isolating themselves. "Everyone is potentially a carrier," Tuggy said.

Testing asymptomatic people would also enable epidemiologists to learn the baseline disease rate in the community and the rate at which the virus is spreading. With that information, they could quarantine anyone carrying the disease, not only those who are obviously sick, Tuggy said.

The Methow Valley Clinic faces a shortage not only of tests, but also of the personal protective equipment (PPE) health care providers need to conduct the tests safely. Under normal procedures, each set of PPE – a full-body gown, face mask and gloves – is thrown away after use. But, since the clinic has only about eight sets, they're putting the PPE back in the bag for a week – so that by the time they need to reuse it, the virus particles have died, Tuggy said.

Clinic staff are also using masks homemade by community members for some procedures and then washing them, so they can save the surgical masks for treating patients with COVID-19 or other contagious diseases.

Easing back to normal

The lack of widespread testing not only makes it harder to control the epidemic, but it will also slow efforts to get back to normal. "We need to solve the testing problem before we can safely reopen," Tuggy said.

Reviving the economy is likely to proceed in fits and starts. As people return to work and other activities, public health officials will have to watch for disease spikes and then isolate people again. Some businesses can operate more easily with social distancing.

"You reintroduce levels of exposure and then clamp down when it flares," Tuggy said. "You need a lot of testing

Photo courtesy of Mike Tuggy

Mike Tuggy is juggling caring for patients at the Methow Valley Clinic with planning for the transition to normal life.

a tremendous amount of patience."

Antibody testing is a crucial part of that process. Once health officials know who is immune, those people could return to work without risking infection or infecting anyone else, Tuggy said. Although antibody tests are being developed, it will take months before there are enough for wide distribution, he said.

And as people return to regular activities, they'll still need to be diligent about wearing masks and washing their hands before and after going to the store or pumping gas.

"Masks aren't bulletproof, but they're way better than nothing," he said. Masks help asymptomatic people from potentially spreading the disease and help protect others from getting sick. They

ing the nose and mouth, giving the person time to wash their hands.

Even once health officials believe it's safe to move toward routine activities, the Methow Valley faces a unique complication. "The challenge is, we're a tourist town," Tuggy said. "It really complicates the situation for Winthrop. People shouldn't travel unless they know they're immune."

Forecast for cases

The Institute for Health Metrics and Evaluation (IHME) at the University of Washington anticipates the peak will hit Washington at the end of April or the beginning of May, based on the current caseload and the rate of new infections.

IHME projects a negligible new

could enable the state to start loosening restrictions, Tuggy said. But that comes with warnings.

"The question of whether there will be a second wave of the epidemic will depend on what we do to avoid reintroducing COVID-19 into the population," IHME said. After the first wave, IHME estimates that 97% of the population of the United States will still be susceptible to the disease. Mass screening, contact tracing and quarantine will be essential to avoid reintroduction and a second wave of the virus, they said.

"People just need to know it's going to evolve. This is the first time an advanced Western civilization with advanced communication tools has faced a pandemic. We'll know better next time," Tuggy said.

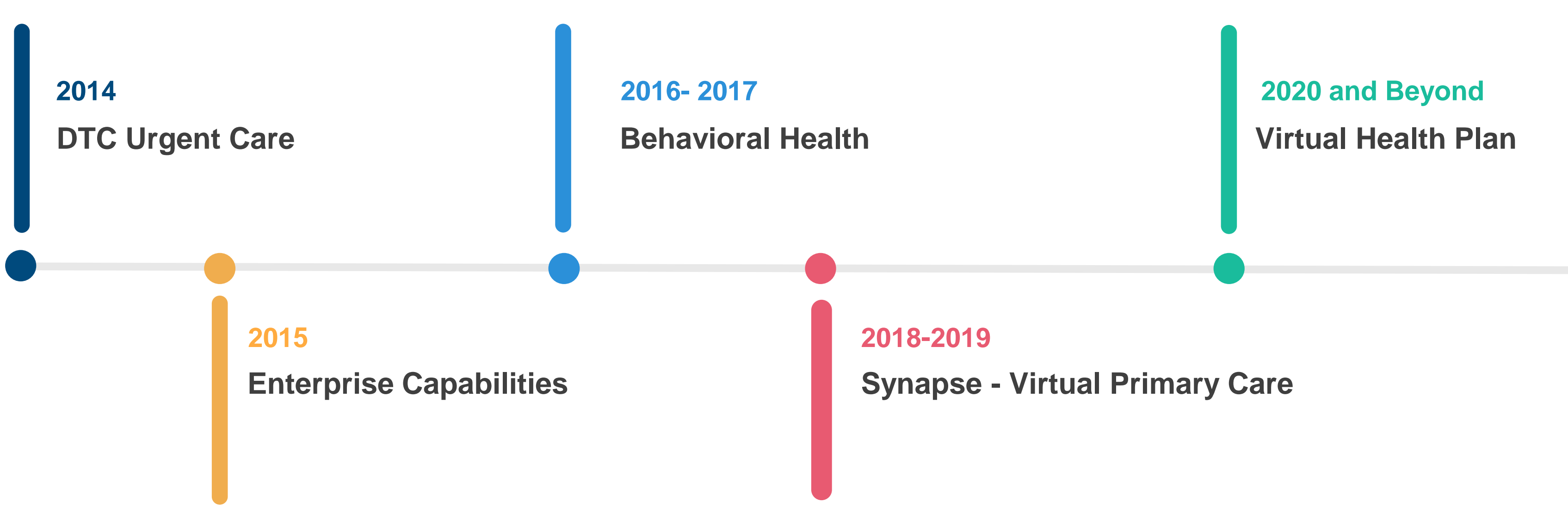
IMPACT OF PAYMENT – FFS IS LOUSY…

- FFS medicine pays poorly for the value we provide to start with and that is compounded during this type of crisis
- Comprehensive payment for primary care services would have allowed us to freely deliver care without financial harm to the practice
- Home visits would have been helpful/safer for seniors with significant conditions who needed eyes on
- Care management

Doctor On Demand

- Nationwide virtual care provided by a collaborative team of physicians, psychiatrists, psychologists and Care Team
- Relationship-Centered approach to high-quality care, multi-modality
- Urgent Care
- Virtual Primary Care with Care Coordination
- Integrated Behavioral Health
- Award-winning, easy to use platform

Doctor On Demand and Continuous Innovation



Health and Well Being Components

Dedicated PCP available for appointments typically within 24 hours and on-demand access to other providers 24/7 for urgent concerns

Integrated behavioral health appointments with board certified Psychiatrist and Psychologists to address underlying behavioral components to chronic illness

24/7 Care Team consisting of NP's, RN's, CMA's, PharmD,and care coordinators available via phone or messaging to assist with questions or support

Regular disease management and coaching with care team to engage patients and support patient in reaching their health goals

Tracking of key measures, personal goals and engagement to encourage progress and effective disease management

Improving Clinical Outcomes

Patients were divided into two groups:

A1C ≥ 7.0

19.3%

reduction in
A1C for ≥ 7.0

33.3%

of diabetics ≥ 7.0
achieved therapeutic
goal ≤ 7.0

A1C ≥ 9.0

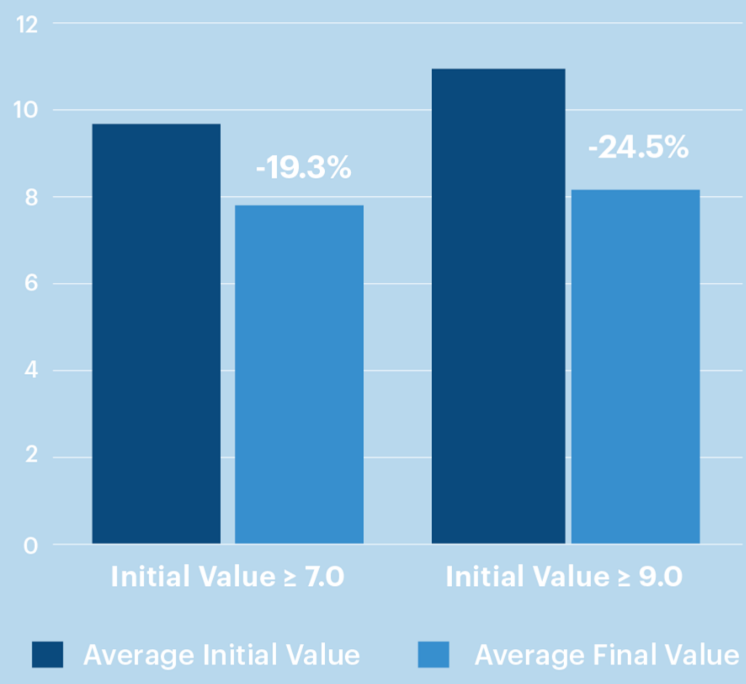
Critically High

58.3%

of patients ≥ 9.0
were reduced below
critical range

24.5%

reduction in
A1C for ≥ 9.0



Proven Clinical Quality

Health Plan Performance Audit: Doctor On Demand visits replace in-office visits

	dr+	In-Office
Antibiotic Rx rate	38.9%	40.9%
PCP visits within 14 days same diagnosis	5.6%	5.6%
Urgent care visits within 14 Days same diagnosis	0.9%	0.3%
Emergency room visit within 14 days	1.6%	1.4%

Telehealth Policy Changes

- Out-of-state licensure requirements waived in over 50% of states
- Geographic and patient setting barrier removed for Medicare FFS
- Cost-sharing waived by commercial and public insurers
- DEA temporarily waived in-person requirements to prescribe controlled substances
- Office of Civil Rights temporarily waived HIPAA violation penalties
- Diagnoses resulting from video-based telehealth can meet Medicare Advantage risk adjustment requirement
- Some states temporarily allowing audio-only visits

Policy Pushed by COVID-19

More older Americans will be able to ***access healthcare*** they need from their home, ***without worrying about putting themselves or others at risk during the COVID-19 outbreak***. Providers will be allowed to use everyday technologies to talk to telehealth patients, more telehealth services will be covered for millions more Medicare beneficiaries, and providers will be allowed to ***offer these telehealth benefits to Medicare beneficiaries at a lower cost than traditional services.***

- Health and Human Services Secretary Alex M. Azar II

Medicare patients can now ***visit any doctor by phone or videoconference*** at no additional cost...A historic breakthrough — this has not been done before.

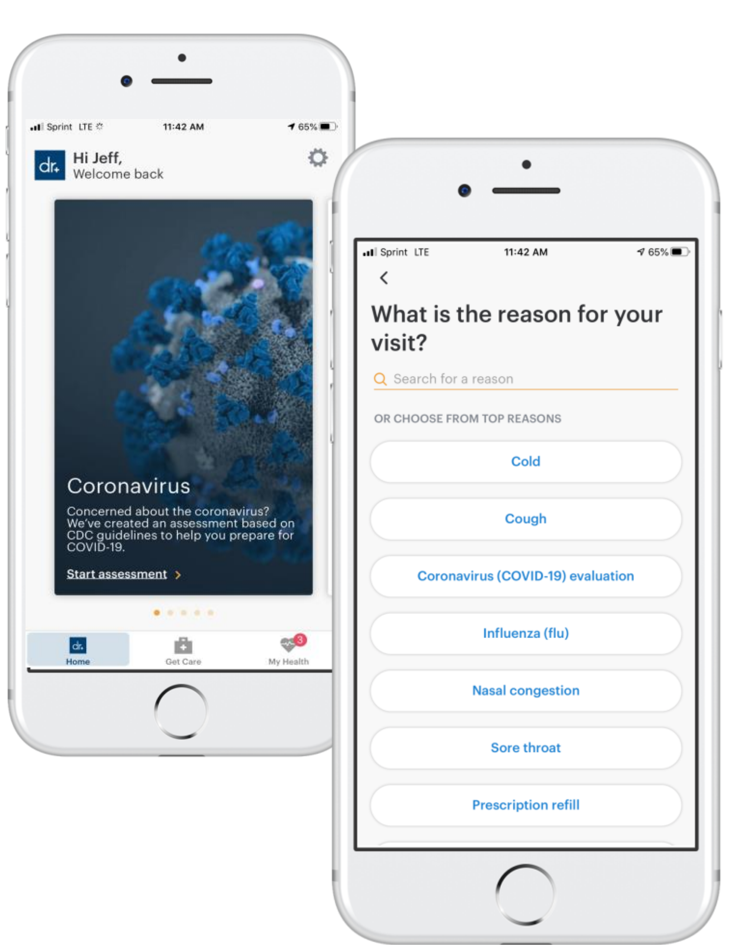
- President Donald R. Trump

Medicare beneficiaries across the nation, no matter where they live, will now be ***able to receive a wide range of services via telehealth*** without ever having to leave home.

- CMS Administrator Seema Verma

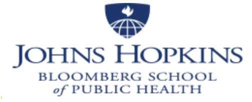
Telemedicine COVID-19 Response

- Online COVID-19 assessment and triage
- Home care guidance
- COVID-19 Information Center
- Appointments for **COVID screening** and **other healthcare needs**
  - **Prevents the spread of infection**
  - **Reduces burden on healthcare system**
  - **Keeps doctors and patients safe**



Doctor On Demand Physicians

- Translating bedside care to virtual care
- Physicians can practice relationship-centered care
- Onboarded over 300 clinicians in the past 30 days
- Spoke to physicians in over 20 specialities
- Average onboarding of 5 days
- Average 17 years board-certified/licensed clinical experience

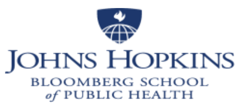


Approaching primary care's role in responding to COVID-19 through a health equity lens

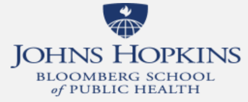
April Joy Damian, PhD, MSc, CHPM, PMP

April 15, 2020

Overview of today's key takeaways



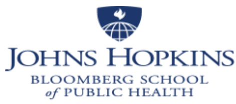
- Key Takeaway #1: The current pandemic highlights and exacerbates persistent disparities, as well as the need to continue advancing the field's efforts in addressing social determinants of health (SDOH).
- Key Takeaway #2: As the backbone of the nation's primary care system for the medically underserved for over 50 years, health centers play a key role in leading the response to COVID-19.
- Key Takeaway #3: The current pandemic demonstrates the urgent need to strengthen the integration of primary care and public health.



The current pandemic highlights and exacerbates persistent disparities, as well as the need to continue advancing the field's efforts in addressing social determinants of health (SDOH).

Key Takeaway #1

The Upstream/Downstream Model for Understanding Social Determinants of Health (SDOH)



A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INTIATIVE

UPSTREAM
DOWNSTREAM

SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation

INSTITUTIONAL INEQUITIES
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations

LIVING CONDITIONS

Physical Environment
Land Use
Transportation
Housing
Residential Segregation
Exposure to Toxins

Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards

Social Environment
Experience of Class, Racism, Gender, Immigration
Culture - Ads - Media
Violence

Service Environment
Health Care
Education
Social Services

RISK BEHAVIORS
Smoking
Poor Nutrition
Low Physical Activity
Violence
Alcohol & Other Drugs
Sexual Behavior

DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)

MORTALITY
Infant Mortality
Life Expectancy

Strategic Partnerships Advocacy

Community Capacity Building
Community Organizing
Civic Engagement

Individual Health Education

Health Care

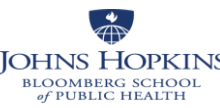
Case Management

POLICY

Emerging Public Health Practice
Current Public Health Practice

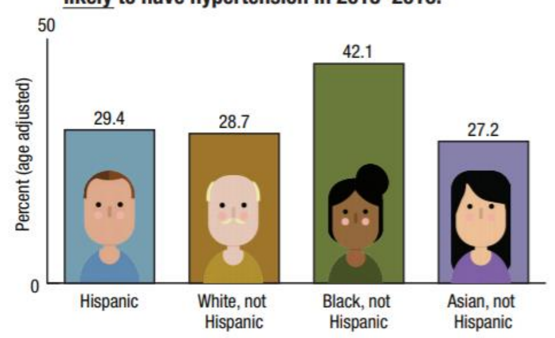
Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

People of color are disproportionately impacted by underlying medical conditions that pose higher risk for severe illness from COVID-19…



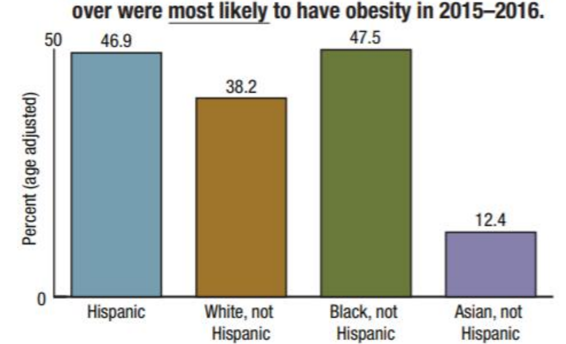
HYPERTENSION

Non-Hispanic black adults aged 20 and over were most likely to have hypertension in 2015–2016.



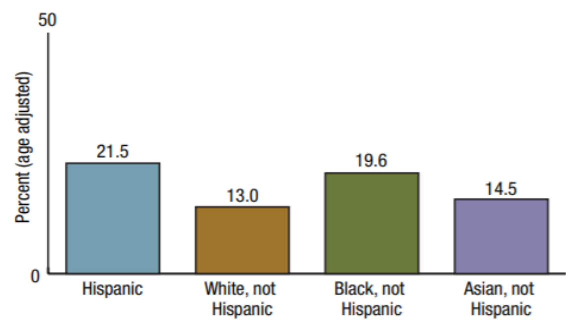
OBESITY

Hispanic and non-Hispanic black adults aged 20 and over were most likely to have obesity in 2015–2016.



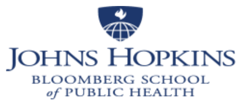
DIABETES

Hispanic and non-Hispanic black adults aged 20 and over were most likely to have diabetes in 2015–2016.



National Center for Health Statistics, National Health and Nutrition Examination Survey (NHANES), 2017.

…but there is still no concerted effort to collect and publicly report on racial and ethnic information of those tested and affected by COVID-19



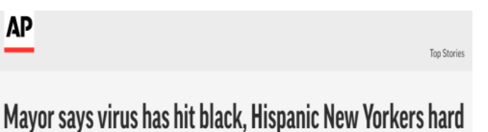
The Washington Post

The coronavirus is infecting and killing black Americans at an alarmingly high rate

The New York Times

Black Americans Face Alarming Rates of Coronavirus Infection in Some States

Mass. Begins Releasing Race Data On Coronavirus, But Only A Third Of Cases Have Info



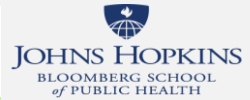
THE BALTIMORE SUN

Black Marylanders make up largest group of coronavirus cases as state releases racial breakdown for first time

"Without demographic data, policymakers and researchers will have no way to identify and address ongoing disparities and health inequities that risk accelerating the impact of the novel coronavirus and the respiratory disease it causes."

- 3/27/2020 Senate letter to HHS Secretary Azar

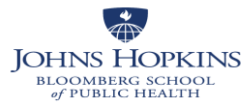
CAUTION
WET FLOOR



As the backbone of the nation's primary care system for the medically underserved for over 50 years, health centers play a key role in leading the response to COVID-19.

Key Takeaway #2

Health Centers' Patient Population



America's health centers serve as the primary medical home for **over 29 million people in more than 12,000 rural and urban communities across every state and territory.**

Nearly **14 million** people in poverty

8.7 million children

1.4 million homeless patients

Over **385,000** veterans

95,000 patients receiving MAT for opioid use disorder

Most Health Center Patients Are Uninsured or Publicly Insured (2018)

82% are Uninsured or Publicly Insured

Medicaid 48%
Uninsured 23%
Private 18%
Medicare 10%
Other Public 1%

Most Health Center Patients Are Members of Racial & Ethnic Minority Groups (2017)

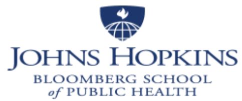
63%
Racial / Ethnic Minority

Most Health Center Patients Have Low-Incomes (2017)

91% are Low-Income

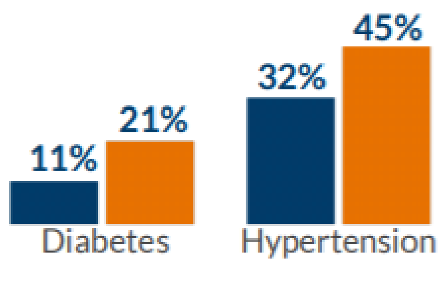
At the Federal Poverty Level (100% FPL) or Below 68%
101% FPL to 200% FPL 23%
Above 200% FPL 9%

Health Centers' Impact on Patients

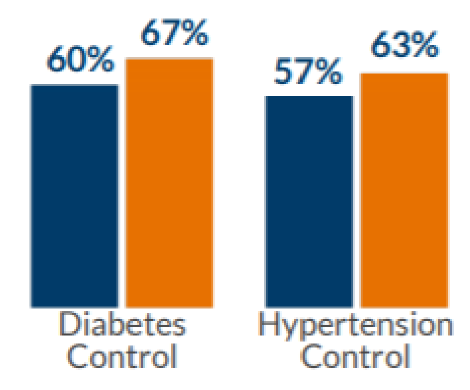


Many Patients Present to Health Centers With Chronic Conditions

% of Adults Reporting Ever Being Told They Have:

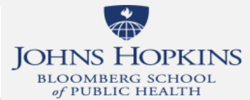


And Health Center Patients Have Higher Rates of Diabetes & Hypertension Control



Health centers perform **better on ambulatory care quality measures** compared to private physicians & are **narrowing health disparities***

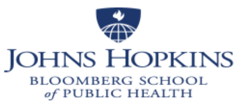
*Shin P, Sharac J, Rosenbaum S, Paradise J. Quality of care in community health centers and factors associated with performance. Kaiser Commission on Medicaid and the Uninsured Report #8447 (June 2013).

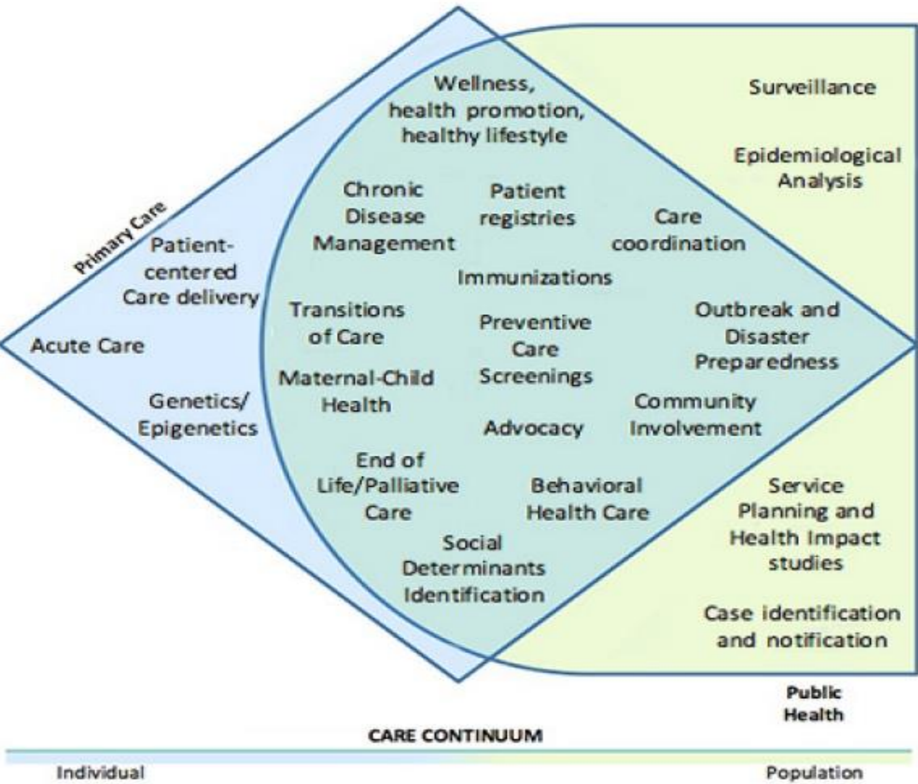


The current pandemic demonstrates the urgent need to strengthen the integration of primary care and public health.

Key Takeaway #3

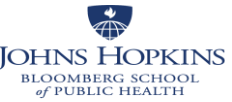
Overlapping Roles of Primary Care and Public Health





American Academy of Family Physicians, Integration of Primary Care and Public Health (Position Paper), 2019.

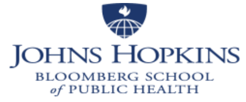
IOM Committee on Integrating Primary Care and Public Health-2012 Recommendations to HRSA and CDC



1. Link staff, funds, and data at the regional, state, and local levels
2. Create common research and learning networks to foster and support the integration of primary care and public health to improve population health
3. Develop the workforce needed to support the integration of primary care and public health
4. Improve the integration of primary care and public health through existing HHS programs, as well as newly legislated initiatives

IOM Committee on Integrating Primary Care and Public Health, 2012.

American Academy of Family Physicians- 2019 Call to Action



Physician Level

- Understand the role public health has to play for you, your patients, and the community you serve
- Demonstrate awareness of integration efforts between primary care and public health

Practice Level

- Redefining population based on the public health definition as geographic as opposed to a practice patient panel
- Recognition and incorporation of the public health infrastructure into the medical neighborhood

Leadership Level

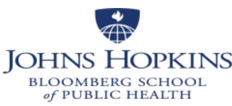
- Facilitate collaboration and communication amongst health systems and public health organizations
- Drive change within hospitals or health systems to partner with public health organizations

Educational Level

- Drive change within undergraduate and graduate medical education to ensure physicians of tomorrow are prepared for a more integrated system

American Academy of Family Physicians, Integration of Primary Care and Public Health (Position Paper), 2019.

Review of today's key takeaways



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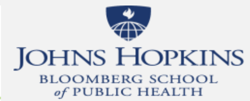
Recognize the challenge, rise to the opportunity



Thank You

April Joy Damian
damiana@chc1.com

Q&A
Discussion