Title: Primary Care Practice in the time of COVID

Summary:
In this Hippo Education short, Sol Behar interviews Oakland, CA based primary care pediatricians Celine Sparrow and Katie D'Harlingue about the impact of Covid-19 on primary care practices. They discuss practical details of how to safely continue caring for their patients, selves and staff members. They also share strategies and resources on how to keep financially afloat during these challenging times.

Marketing Assets

- Please identify guest Twitter/Facebook/Instagram handles here: __n/a___
- Covid-19 has altered the face of primary care practice. Hear from two primary care pediatricians the steps they have taken to keep their patients, their staff, and themselves safe while continuing to manage a viable business in this challenging new world.

Shownotes:

1) how has covid affected your daily practice?

-Covid 19 has greatly impacted our practice on a nearly daily basis
-Throughout this time, we have tried to align changes in our practice with state and county government orders, CDC and AAP guidelines
-the major categories of changes within our practice have included: 1) **scheduling and clinic workflows, 2) staff safety and 3) medical decision making, and 4) addressing social determinants of health**

<u>1)What types of appts are seeing and how? (scheduling, triage, rooming)</u>
- Once shelter in place order in effect (march 17), stopped seeing all medically unnecessary/ non-urgent visits in the clinic
-Large move to telehealth
-Well child visits/Vaccines:
- At first, we postponed all well child visits over 2 months due to concerns of possible asymptomatic spread in the clinic and low testing capacity. At that time we considered a brief delay in vaccines less of a risk than covid. We also thought it sent an important message to our families about the need to stay home and avoid contact with others outside of their households.
-Then, as recommended by AAP guidelines, and seeing that our county was not a particular hotspot, we altered our practice to include babies up to 15 months for wcc/vaccines. (doing 9, 18, 24, 30 mos visits on phone, emphasis on development) -- may expand to vax only visits for 4 adn 11 yo soon
-separate waiting rooms, rooms designated as sick rooms and well rooms
- see well visits in the morning and sick visits in the afternoon.
-Asked about illness the day before in visit reminder calls
-reducing medically unnecessary procedures that would contaminate work areas, i.e. weight not taken unless necessary
-Any drop in is triaged by an RN in full PPE and only seen in clinic after discussion with an MD. If safe to be phone visit only, is sent home for phone visit

2)Staff safety

-All staff with risk factors such age >65 or compromised immune systems or certain chronic conditions *are given the option* to work from home and do telehealth only
-Also having fewer providers in clinic-- can either take off time or work from home to limit exposure
-All greeters wear full PPE and all patients and family members are given surgical masks and hand sanitizer upon entering the building
-All medical assistants, front desk workers, medical providers wear surgical masks *and gloves* for well patients
-For sick patients with fever and/or respiratory symptoms, MAs and providers wear full PPE (N95, goggles or faceshield, gloves, gown)
-social distancing in clinic-- must wear mask if cannot be socially distanced, virtual meetings
-hourly wipe down of high touch surfaces-- phones, door handles, etc
-staff encouraged to wear scrubs, change clothes before going home, etc.
-wiping down every room after patient leaves, even if no sx.

3)Clinical decision making

-Clinical decision making has been most impacted when assessing sick patients by phone. We are constantly asking ourselves: do I need to bring this patient in? Is it worth the risk of possible covid exposure?
-In our practice, most of our families have limited internet access and low tech literacy, so we primarily do phone calls and have patients send photos and recorded videos
-Specific telehealth clinical challenges include: when to treat certain conditions with empiric antibiotics, whether it's ok to prescribe steroids for asthmatics without a lung exam, how to evaluate patients with chronic cough, evaluation of fever <1 year of age, prolonged fevers, how to assess abdominal pain, weight follow ups for children failing to thrive
-Many of our families don't have thermometers at home and are not able to find any in stores currently, so our best "vital" sign is often our gestalt
-Anecdotally, empowering parents to help us be their doctors has been very useful. I ask parents to palpate abdomens, when available to hop on home scales with their children in their arms and then weigh themselves to estimate weights and to tell me how worried they are and whether they would be ok with a follow up call the next day
-Respiratory distress in younger children is pretty easy to assess by recorded video and I've been able to have parents record 10-15 seconds of a belly and decide whether a child needs to go straight to the ED
-Since we see sick visits in the afternoon and our clinic site does have sufficient PPE and covid testing capability, we do bring patients in to be seen when a telehealth evaluation is insufficient given the clinical concern. Since we are not seeing any other well patients or healthy follow ups then, we can room patients immediately and limit exposure in the waiting room

4)Addressing Social Determinants of Health

-The pandemic has also changed the way we screen for and address social determinants of health.

-Our families already face immense economic hardship, food insecurity, limited access to resources, immigration challenges. Although most of us were screening for these in our practice previously in our well checks, we now screen for these with every phone call and in person visit. We do instant referrals to our case manager and have developed a packet that we hand out, mail or email with resources in our community. Anecdotally, I've had several families ask me whether receiving food bank support might put them at risk for losing their immigration cases in the future due to the public charge rulings. Many families have been hesitant to ask for help and every opportunity must be used to provide education and support.

2) how are you deciding who needs to be seen in person vs via telemedicine- is there aap guidance?

This can be divided into 2 major categories, **well care and sick care:**
For well care:
-The AAP put out updated guidelines on 4/15/2020 recommending that well child visits should be continued in person whenever possible. *If community circumstances* require limited in-person visits, then newborn care, well child visits and immunizations through 24 mo of age should be prioritized.
-It is important to note the limitations of well visits by phone and ensure the visits are completed in person when possible to include a complete physical exam, vision, hearing etc. Vaccines must be prioritized to prevent future pandemics.
-Community circumstances can be broken down into 3 categories:
1)Virus prevalence - dependent on testing capability
2)PPE availability - required to protect patient staff
3)Community vulnerability - what are the risks of viral spread and complications from Covid-19 in the particular population served by the clinic?
*Anecdote: In our clinic, the majority of the caregivers of my patients work or are trying to work in grocery stores, food preparation/delivery, construction. To get to their jobs, they rely on public transport. They live with grandparents and often other families in crowded quarters. They and their grandparents have diabetes. Many of them have not completed high school or are illiterate.
-viral spread can increase in overcrowded or inadequate housing, multi-generational housing, and communities with essential workers, dependence on public transport, and low levels of medical literacy
-Data from the CDC clearly shows a disproportionately higher rate of complications in African Americans and Latinos. This population makes up the majority of our essential workers and already has higher rates of certain chronic diseases like obesity, hypertension and diabetes related to poverty and the epigenetic effects of intergenerational oppression and discrimination.
For sick visits:
-The AAP recommends separating sick from well visits as much as possible, such as seeing sick patients in the afternoon or at a separate site to avoid cross contamination and limit crowding in the waiting room. We see our sick visits in the afternoon. When deciding whether to bring a sick patient in we tend to bring in moderately ill children to make an assessment and determine whether hospital care is needed (for example: some asthma

exacerbations and/or respiratory distress, abdominal pain with concern for acute abdomen, moderate dehydration etc)

3) the economic toll to pmd's has been immense- what are some strategies out there to mitigate the economic damage to your practice and how have you practically do this while keeping yourselves and employees working and safe? (Does aap have guidance? If so- what's the gist of the message?)

-initially, visits grinded to a halt. This was particularly true for our dental, optical, and school base health centers-- trying to re-deploy staff at other sites
-medical sites -- only medically necessary visits
-quick pivot over to teleheath
-increasing phone call visits-- medi-cal reimbursing fully for these visits; some private insurances require video component
-running patient lists to call those who have chronic illnesses to check in-- DM, asthma, ex-premie, depression, adhd, etc.
-doing some developmental screening visits on phone for little kids due for wcc (that don't require vax)
-for kids due for PE/wcc, doing phone visit and billing for whatever comes up (developmental concern, family stress, obesity, etc), then later see for full WCC-- will get to bill for both then
-to avoid cutting hours/work reductions, are asking for volunteers who want to take off time (child care, etc)
-as an organization, we have applied for a lot of grants and relief money
- Documenting how many hours staff leadership are spending on COVID, get reimbursed for this
Through the Families First Coronavirus Response Act (FFRCA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, new resources are available to small businesses, such as pediatric practices. Also funds in each relief package for CHCs.

- The first stimulus bill included $100 million for Community Health Centers. Our allocation (using a formula with a base amount and per patient and uninsured patient) was $145,000.
-The CARES Act included $1.3 billion for CHCs. Our allocation was just under $2.5 million.
-La Clinica has also received $142K and $862K from Medicare.
-For some context, a Day of Cash (that is on average what we spend every calendar day) is about $300,000. So the first stimulus award was worth less than half a day of cash, and the second just over 8 days of cash.

4) how are you protecting yourselves and your staff? How did you procure PPE? How can those lacking it get it?
Katie:
-all staff required to complete a daily symptom log and turn it in every 2 weeks
-strict return to work guidelines based on CDC recommendations

- greeter at the front door gives all patients a mask and hand sanitizer, screens for sx c/w COVID-- separate elevators for sick/non-sick
-staff wearing simple surgical masks and gloves for all asymptomatic patients, front desk included
-full PPE with N95s, gogles, gowns, gloves etc for symptomatic patients
-protecting ancillary depts-- informing PUIs to go home, not visit pharmacy, lab, etc
-only allowing patient to come in; if pediatric patient- one adult only with them, no one else
-drive up testing done in cars- limits exposure (prescreened on phone)

-Materials management dept reaching out to new vendors
-We have had a lot of donations of PPE-- private and from donations given to county DPH
-Using live documents through google docs across all our clinics sites-- inventory of all the PPE a site has, sites required to update daily, want to keep each site with around 2 weeks of PPE, not more or less as want to spread it equitably and not let a site "hoard", gets redistributed if needed
-Can reach out to the local department of public health, i.e. when state of California released 21 million N95s, that went to the counties, then delegated to the practices.
-Reach out to your local Children's hospitals as they may have received surpluses of donations. For example, those practicing in the Bay Area can reach out to Children's Hospital Oakland and contact **Eamon Loughnane at 510-428-3596** who is in charge of distributing surplus PPE to providers

<u>Importance of stretching out existing PPE supplies:</u>
-CDC has recs regarding contingency planning for PPE-- i.e. can use cloth gowns in PPE scarce situations,
-extended use and re-use of PPE-- CDC has guidelines (link below) -- especially important for masks; extended use is safer than re-use
-hiding supplies from patients-- hand sanitizer, gloves kept in cupboards

Tags:
Practice management, pediatrics, ID