THE COVID-19 PANDEMIC DIGEST

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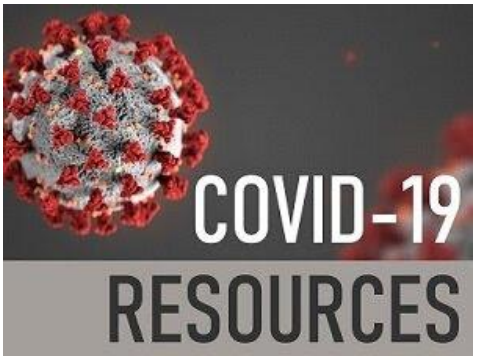
"We call on all countries who have introduced so-called "lockdown" measures to use this time to attack the virus.

You have created a second window of opportunity. The question is, how will you use it"

World Health Organization, March 25th, 2020



March 30th, 2020 Edition

Dear Colleagues,

We have an opportunity in front of us. As the acceleration phase of the COVID-19 pandemic brings it inland, the AAFP has partnered with other national health care organizations to gain governmental buy-in to suppression and containment strategies. With elements of these strategies now in place across numerous states, there is hope that we can begin to "attack the virus" locally, slow its spread, prevent its resurgence, and ultimately save more lives.

The work for family physicians on the frontlines is far from over, instead promising to become increasingly difficult in the upcoming weeks. Rest assured that we here at **WAFP** are standing by your side and advocating for your needs during this COVID-19 pandemic.

We are listening. Although some of our advocacy efforts were manifest in the $2 trillion Coronavirus Aid, Relief and Economic Security (CARES) Act that was passed on March 27th, we recognize that **family physicians still need more relief**. We therefore continue to advocate heavily for better training, expansion and financial support of our health care workforce. We continue to fight for legislation enabling you to provide safe and effective care through telemedicine, including appropriate protections and compensations. We continue to aggressively push for rapid supply of testing materials and personal protective equipment (PPE). We continue to support the safeguarding of facilities in the treatment and isolation of COVID-19 patients. We continue bring clarification to guidelines on management and treatment of COVID-19 cases. Finally, we continue to refocus government on suppression and containment measures – **current efforts are simply not enough**.

Highlights of our advocacy efforts and the CARES Act are featured in this digest, as are updates on the COVID-19 pandemic. As we move into the next phase of this pandemic, we ask you to consider taking four minutes to **complete the survey emailed to you on March 27th** to direct our advocacy effort. Please also consider providing firsthand COVID-19 accounts or using the COVID-19 Speak Out tool. Alongside the Academy's detailed analysis of the bill, your input will help ensure lawmakers understand our concerns.

We thank you for helping provide stronger medicine for America.

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STRATEGIES TO SUPPRESS & CONTAIN COVID-19

Global Strategies

As of today, the Johns Hopkins University & Medicine COVID-19 Global Cases Map reports an international total of over **735,000 cases**, with **59,000 cases added** on March 28th, and a **fatality count of 35,000**. Proportional to population size, **Spain** leads all 10 most affected countries with the highest caseload per 1 million inhabitants. Global suppression and containment efforts by border closure appears to have been **too late**, necessitating internal "lockdown" of **almost 25% of the world's population** by local governments, including 1.3 billion people in India. Graphically, the caseload in many countries is steeply rising; meanwhile, China's curve appears to have plateaued months after their lockdown measures were initiated.

U.S. Strategies

America now has the highest burden of COVID-19 in the world, leapfrogging over Italy and China, to almost 145,000 cases and counting. Twenty states are reporting more than 1,000 cases. Fatalities lag behind at 2,500, including one infant death, but have been *doubling* approximately every two days. **New York**, with the highest caseload at 60,000, has 965 fatalities. With ongoing shortages in PPE as well as hospital capacity, these rates are expected to continue. **Long-term care facilities** across the nations are reporting outbreaks as well, prompting CMS to make site inspections effective immediately.

As COVID-19's incidence continues to rise (19,000 cases on March 28th), around **172 million residents** across over 20 states are under at least partially-enforced **"Stay at Home"** orders. Projections suggested that last week was the final week in most states for these social orders to have made a preventive, suppressive impact; without them more uniformly in place, U.S. fatalities were projected to reach a **total of 1-2 million**. As part of the Council of Medical Specialty Societies, the AAFP has supported a letter calling on the administration to develop **a stronger, nationwide plan for social distancing,** that should remain in place until healthcare experts indicate it can be safely lifted.

Wisconsin Strategies

Here in Wisconsin, cases have risen to 1,112, with 565 of those in **Milwaukee;** this is the 20th highest case load across all states. At least 13 cases are from within **Village Point Commons senior living facility** in Grafton, where the National Guard has since been deployed. State fatalities have reached 13 so far, five of which are in Milwaukee, where the public health department has also observed that 52% of all cases (and a disproportionate 62% of male cases) are **African-Americans**. With our state-wide "Stay at Home" order now in place, we hope in the coming weeks to see a slowing of spread, and opportunities to focus on treatment and eradication.

STRATEGIES TO MITIGATE COVID-19

Reducing COVID-19 Exposures

Telehealth is our critical mitigation strategy to reduce health care exposures to COVID-19. The AAFP townhall on March 25th discussed its implementation issues in depth, including adjustments to billing codes and reimbursement. Member feedback highlighted that, although video components were required for reimbursement of telehealth E/M visits, they were not appropriate, feasible or helpful for many of our patient populations, including the elderly. The AAFP wrote a letter to CMS requesting they begin **paying for telephone-only encounters**. The AAFP COVID-19 Telehealth Guidance page was also updated to reflect recent changes.

Since then, the CARES Act changes to telehealth have made it more broadly available to patients through **(1)** the elimination of need for existing relationship with a patient to offer them telehealth services during the pandemic; **(2)** ensuring that health plans with high deductibles cover telehealth services for patients prior to them reaching deductibles and **(3)** ensuring that Medicare will cover costs to furnish patients of FQHCs, community health centers and rural clinics with the appropriate equipment to participate.

Importantly, **managing vulnerable populations remotely** has become all-the-more challenging in this pandemic. The CDC COCA call on March 27th highlighted how to manage patients at higher risk for COVID-19 due to underlying chronic conditions, including **health care workers** with these conditions. Earlier teleconferences highlight their COVID-19 strategies for management of pediatric and obstetric patients, as well as patients in long-term care facilities.

Addressing Global Inventory Shortages

Testing Kits

The WHO and the CDC continue to advocate for broad testing for COVID-19; however, both have recognized that this strategy remains unrealized due to testing material shortages. Notably, the CARES Act has released **$91 billion** towards development and accessibility of diagnostic tests, treatments and vaccines. Already authorized under new FDA guidelines, a 5-minute point-of-care COVID-19 test by Abbott will begin production this week.

Until testing supplies are well-distributed, we recommend awareness of the CDC's COVID-19 guidelines and immediately notifying your local or state health department if you suspect a patient has COVID-19. In these guidelines, screening patients for COVID-19 remains based on exposure "risk level", as well as symptoms. Based on positive screening criteria, as well as potential disease impact, the CDC recommends this priority list for COVID-19 testing.

Where supplies are limited, if **milder symptoms** are noted in lower-risk patients, home-based isolation and recovery can be implemented **without testing**. For more severe cases, the CDC recommends that **testing for other respiratory illnesses should be performed** for those presenting with respiratory symptoms.

Personal Protective Equipment (PPE)

In February, the WHO announced a worldwide shortage in PPE. Now in America, **89% of physician practices already reported shortages of critical PPE**, per an MGMA survey this month. In response to physician outcry, on March 27th the AAFP released a position statement about PPE shortages. Along with four other organizations including AMA, we implored congress to urgently attend to our imperative PPE needs. The CARES Act response was **$16 billion** towards a strategic national stockpile to increase the supply of ventilators and masks.

The CDC continues to provide guidelines on PPE use and endorses strategies to increase longevity of PPE until more supplies become available. Further explanations can be found on the recordings of their COCA call on March 25th. Notably, **NIOSH and NPPTL standards** for facemasks, respirators and self-contained breathing apparatuses are being reviewed by the CDC, who are also considering stripping certain countries delivering sub-par equipment off the approved list.

Protocols for Treatment

As mentioned above, the CARES Act promises to release heavy funding and more faciliatory regulations for development of COVID-19 treatments and vaccines.

Until then, **for milder cases**, the resounding strategy from the WHO and the CDC remains to have the patients stay at home and use supportive treatment measures. **NSAIDS are currently still an option.** Where testing supply is limited, based on newer data, the CDC recommends that isolation can be discontinued without retesting at seven days after symptom resolution. Retesting is ideal, if available.

For more severe cases, treatment strategies remain **experimental**. The CDC is vigilantly reviewing information to provide up-to-date and safe clinical care guidelines. There are still **no FDA-approved medications** for the treatment of COVID-19. There are definitive recommendations that corticosteroids **should be avoided**. Supplemental oxygen and "compassionate use" of **hydroxychloroquine** along with **azithromycin,** are commonly employed. Investigational therapeutics are available **via clinical trials,** and include broader application of hydroxychloroquine, as well as **Remdesovir.**

Importantly, the CDC and the FDA have issued a health alert about chloroquine phosphate**,** which is part of some COVID-19 clinical trials but is also commercially available chemical for aquarium use. There is concern that individuals have begun purchasing and using this for prophylaxis; two cases of toxicity have been reported, one of which was fatal. **Patients must be advised against non-pharmaceutical use of chloroquine.**

Addressing Health Care Facility Shortages

Multiple epidemic experts, led by Matthew Biggerstaff, have provided the CDC with COVID-19 projection scenarios. Their calculations suggested that in worst-case scenarios, **"2.4 million to 21 million people** in the United States could **require hospitalization."** With only 924,000 staffed hospital beds, and less than 10% of these available for critical care, this would cripple our medical system. Already we see cities running close to or beyond hospital capacity. Many states are thus re-opening old hospitals or repurposing larger venues such as hotels or sporting arenas to accommodate this surge. US troops, as well as naval and military field hospitals will be deployed to NYC, Seattle and Los Angeles, to decrease local hospital burden of non-COVID-19 cases.

The CARES Act will release **$100 billion** to support hospital costs, including $250 million for surge capacity. Until then, across Wisconsin, we have an estimated 12,500 beds across 152 hospitals, only 2,500 of which can be used as ICU beds. Strategies are being devised to convert other beds for ICU use, and to free up existing beds (such as cancelling elective surgeries). City-specific predictions, suggest that more urban regions such as **Milwaukee, Madison** and **Green Bay** will need to **expand bed capacity** during the pandemic – even if only 40% of the population was infected, and only 8% require care. Suppression, containment and mitigation remain our more potent strategies to preventing these scenarios from being realized.

STRATEGIES TO STRENGTHEN THE COVID-19 WORKFORCE

Health Care Worker Case Surveillance

With projections estimating up to 81% of Americans becoming infected, the COVID-19 strain on our health care workforce is gravely concerning, particularly without adequate social and physical protections in place. Reports from Italy and Spain already suggest that between **10% to 14% of those infected are health care workers** at this point. Locally, of the top 10 most affected states, data on affected health care workers has been reported in California and in Massachusetts. Ohio has also reported a concerning 16% of confirmed cases in health care workers. Many health care workers are **calling for national surveillance and reporting** on these numbers, to help support capacity planning and advocacy efforts. While not an outlined service in the CARES Act, the $4.3 billion dedicated to public health services including state and local health agencies provide an opportunity for this purpose. Funding was also allotted to hire more workers.

Support for Family Medicine Trainees

In terms of additional capacity, across the U.S there are approximately 90,000 medical students being trained at more than 150 medical schools. At the epicenter of America's COVID-19 infection, NYU has offered to **graduate its 4th-year medical students three months early** to aid in frontline care. Nearby, four Massachusetts medical schools have agreed to do the same. It is not known if other medical schools are considering similar options. Notably, AAMC has developed guidelines on the role of medical students during this pandemic.

Also in training, family medicine residents in the U.S. have two new concerns during this pandemic. The first concern is that **visa processing** was suspended, which affects around 25% of incoming family medicine interns, as well as a similar proportion of existing residents. Importantly, the AMA and the ECFMG urged the U.S. Department of State and Department of Homeland Security to expedite visa considerations for all non-U.S. citizen international medical graduates, which was approved. The second concern is that **board certification exams for graduating residents remain on hold**, which could potentially lift supervisory requirements and thus workforce burden in upcoming months. The ABFM is working to have supervised board exams in the summer. Notably in Canada, physicians are pleading to reinstate the cancelled residency board exams in an online format.

Financial Support for Family Physicians & the Health System

Finally, we are acutely aware that many family physician practices are threatened by the economic impact of COVID-19. Some employers have already announced cuts to physician salaries and retirement funds. **The AAFP is working to ensure your practices remain viable**.

We advocated in a letter on March 20, 2020 for the COVID-19 stimulus bill to allow our physicians to have "tax relief, no-interest loans, direct payments, payment for virtual visits including phone calls, and other measures". We also wrote a letter to HHS Secretary Alex Azar and CMS Administrator Seema Verma requesting that they activate the Periodic Interim Payment program and thus allow physicians to **request advanced payments for services**.

The response in the CARES Act includes **(1) $100 billion** towards a Public Health and Social Services **Emergency Fund** for eligible providers for healthcare-related expenses or lost revenues associated with COVID-19, available based on approved rolling applications; **(2) $1.38 billion** in supplemental funding for **community health centers**; **(3)** reauthorization of the Health Resources and Services Administration **grant programs** that promote the use of **telehealth technology** and strengthen **rural healthcare; (4)** small business loans, economic injury disaster loans, a paycheck protection program, and some loan forgiveness that will not be included in income tax; **(5)** suspension of payment sequester policies that would reduce reimbursement.

We also advocated in our March 20th letter that **telephone-only encounters be reimbursed**, and that telehealth be reimbursed at the rate of regular visits. These adjustments to reimbursements do not seem to have been made in the CARES act.

Again, the Academy is currently undertaking a detailed analysis of the CARES bill and how it will impact family physicians. Armed also with your accounts detailed how the COVID-19 pandemic has impacted you and your practice, we aim to show lawmakers that our workforce resilience, and thus the health of the nation, depends on more tailored support for family physicians.

We will continue to report updates on our advocacy efforts as they become available.