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Remote Substance Use Treatment Faces Quarantine Test

To recover from addiction, people with substance use disorders (SUDs) need support from providers and their peers. As quarantine has become a way of life, and gatherings have been banned in most states for the foreseeable future, both are hard to come by. One possible solution is telehealth, but experts say that remote, tech-aided treatment for addiction is still largely unproven — and most payers and providers don't have experience with it.

"Because of the unexpected nature and unprecedented nature of the situation, there are very limited data on evidence-based approaches on how to treat patients under these circumstances," said Carlos Blanco, M.D., during a May 18 webinar about continuity of care for SUD patients, organized by the National Institute for Health Care Management (NIHCM), a health care think tank. Blanco is the director of the Division of Epidemiology, Services, and Prevention Research at the National Institute on Drug Abuse, a branch of the National Institutes of Health.

"Related to that, [there is] a lack of epidemiological and outcome data," on the present status of people with SUDs, Blanco added. "So although we suspect that there have been increases in substance use and substance use disorders [during the COVID-19 pandemic], we don't have the data to know this for sure. Also, there's a lack of outcome data regarding the treatment modifications that have been made."

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Payers Use Apps to Keep People Informed, Healthy During Pandemic

As the COVID-19 crisis tightened its grip on the U.S., industries from restaurants to retail turned to technology to better serve customers who were sheltering at home. Health insurers were no exception, as tech played a major role in their response to the public health crisis. In fact, some insurers took the opportunity to develop new virtual apps or reconfigure existing ones in order to help members face the myriad challenges posed by the new coronavirus.

Two such insurers worked with Microsoft Corp. to bolster their efforts. Most recently, UnitedHealth Group partnered with the technology company to launch a "return-to-workplace" protocol, supported by a smartphone app called ProtectWell, which aims to help companies safely transition their workers back to the office as state restrictions loosen.

The app includes a bot powered by artificial intelligence that asks users questions to screen them for COVID-19 symptoms or exposure, according to a May 15 press release. If the app finds that the employee might be infected, it can direct the person to a "streamlined COVID-19 testing process that enables closed-loop ordering and reporting of test results directly back to employers." ProtectWell also includes guidelines and tips on subjects including physical distancing, personal

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hygiene and sanitation, and employers can also choose additional content that is customized for their workforce.

Pittsburgh-based Highmark Inc., meanwhile, tapped Microsoft to develop and launch a COVID-19 Symptom Checker Healthbot, which the Blue Cross Blue Shield insurer made available to the general public but also customized for its members. The development of the symptom checker app coincided with the company's move to reconfigure its highmarkanswers.com website, which it originally developed to address customers' questions about a large health care system going out of network, explains Stacy Byers, Highmark's vice president of customer experience.

Initially, the new answers that Highmark built into its website were very "insurance heavy," as they addressed questions such as "Where should I go for testing?" and "Am I covered for testing?" Byers says. But since the insurer had an existing relationship with Microsoft and knew about its symptom-checker bot, discussions began about how to incorporate that feature into Highmark's platforms.

"The Microsoft bot is used by the [Centers for Disease Control and Prevention], so it is an out-of-the-box capability, but it can be tailored to the context in which it is provided to the consumer," she says. "Those were the pieces that we had to work through — where did we want to guide our members when the bot would offer up certain kinds of answers about how to get care?" Thus, the tool is able to guide Highmark's customers to, for example, the insurer's member services department or to local resources based on their location, according to Byers.

Highmark said in an April 27 press release that its symptom checker saw more than 30,000 visits in the first week it was available on highmarkanswers.com. In an email sent to AIS Health on May 20, a company spokesperson said the healthbot had seen 50,000 unique sessions at that time.

Now, Highmark is contemplating its next phase of customer-assistance efforts, Byers says, noting that "we've already been hearing from various partners who are developing contact-tracing applications." Additionally, "as an insurer, our employers were coming to us and asking for assistance on getting their employees back to work safely," she says. "So some more messaging and tool development had to really start to shift toward [that]."

Brook App Offers Health Advice

At Albany, N.Y.-based Capital District Physicians' Health Plan, Inc. (CDPHP), a smartphone app that the nonprofit insurer had been using to help its members manage diabetes ended up also being a valuable tool in its COVID-19 response.

CDPHP said in an April 28 press release that it's offering the Brook Personal Health Companion to both members and nonmembers "for free support throughout the duration of the COVID-19 crisis." The app provides guidance in areas such as maintaining a healthy immune system, staying active around the house, making healthy meals, improving sleep, reducing stress, and managing blood pressure and blood sugar levels.

Even before the COVID-19 pandemic hit, CDPHP had been working on "evolving" its use of the Brook app beyond diabetes management, Jennifer Regan, the health plan's director of consumer engagement, tells AIS Health. But when the coronavirus began its rapid spread in the U.S., CDPHP decided "to leverage that [app] for people who wanted support in answering quick questions on a wide array of different health topics" during the crisis.

While anyone can download the Brook Personal Health Companion app from that company's website, CDPHP customized the tool for members so that it is able to offer

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Senior Reporter, Peter Johnson; Managing Editor, Leslie Small; Executive Editor, Jill Brown Kettler

health-plan-specific content and direct them to appropriate resources, Regan says. "So if one of our members is using the Brook app, and the interactions with one of the Brook experts leads to something that warrants serving up additional information like promoting our telemedicine program… or some other resources that we have, that is what we've been working on the past couple of months to make it more relevant and more specific for our members' experience."

CDPHP tracks its members' usage of the app, and has seen about a 15% spike in enrollment in the Brook program since it put in the new coronavirus-related features, according to Regan, who adds, "I suspect that will continue now that we're doing even more promotion around it to make folks aware of this resource."

Even when the current public health crisis eases, CDPHP wants members to continue to find the Brook app helpful. "I hope this is a catalyst for people to continue using it, but then I think that puts the onus on us in the product development team to keep the content relevant," Regan says.

CMS Final Rule Bolsters Telehealth, Allows ESRD Patients to Enroll in MA

CMS has finalized a set of proposals for Medicare Advantage and Part D plans that encourage MA plans to increase their telehealth benefits and give end-stage renal disease (ESRD) patients the right to enroll in regular MA plans. CMS also said it is moving forward with plans to increase the impact that patient experience and access measures have on plans' overall Star Ratings.

The finalized rule, slated for June 2 publication in the Federal Register, gives MA plans more flexibility to count telehealth providers in certain specialty areas — including dermatology, psychiatry, cardiology, ophthalmology, nephrology, primary care, gynecology, endocrinology and infectious diseases — toward meeting CMS network adequacy standards.

"This flexibility will encourage plans to enhance their benefits to give beneficiaries access to the latest telehealth technologies and increase plan choices for beneficiaries residing in rural areas," CMS said.

Lindsay Bealor Greenleaf, vice president of policy at health care consulting firm ADVI, tells AIS Health that MA plans already are offering various telehealth supplemental benefits for patients with chronic diseases. "The telehealth momentum is likely to continue beyond the pandemic, unless significant quality or fraud concerns arise along the way," she says. "This is playing out in real time, so it will be a while before we can look back and review how well telehealth expansion is working."

The ESRD rule change, meanwhile, implements the requirement contained in the 21st Century Cures Act to give all beneficiaries with ESRD the option to enroll in an MA plan beginning in 2021. Previously, CMS rules allowed ESRD patients in MA plans under limited circumstances.

CMS also said it is finalizing proposals to increase the weight of the patient experience/complaints and access measures in the Star Ratings system, and to use the Tukey method for removing outliers before calculating star measure cut points. But the agency is delaying the timeline for both changes: it will increase the weight of the relevant measures from 2 to 4 beginning with the 2021 measurement year (not the 2020 measurement year when the COVID-19 pandemic started), and the Tukey outlier deletion will take effect with the 2022 measurement year, to be reflected in the 2024 star ratings. Meanwhile, an interim final rule posted in April will modify the calculation of 2021 and 2022 Star Ratings to address potential disruptions with data collection and measure scores posed by the pandemic. Other proposed Star Ratings policies will be addressed in a future final rule, CMS added.

Greenleaf notes the final rule did not address two other anticipated potential rule changes — one that would establish a second preferred specialty tier in Medicare Part D, and another that would require real-time benefits tools — due to the effects of the COVID-19 public health emergency. CMS said these proposals will be finalized "in subsequent rulemaking" and will not take effect any earlier than Jan. 1, 2022.

View the CMS fact sheet and download the final rule at https://go.cms.gov/36OhB6h. Contact Greenleaf via Matthew Dick at matthew.dick@pinkston.co.

by Jane Anderson

SafeDistance App Assesses Risk

The HealthPartners Institute, which is part of the Minneapolis-based integrated health system HealthPartners, teamed up with researchers at the University of Minnesota to create an app with a very different purpose: helping people avoid potential COVID-19 hotspots.

While most COVID-19 tracking maps at the time offered only county-level data and only reported cases confirmed by testing, the SafeDistance app displays data showing both potential and confirmed cases, and it breaks down the data at a neighborhood level based on census block groups, explained an April 22 press release.

> **Basically, if you're in an area that has lots of COVID, you're in a high-density neighborhood, and there's lots of foot traffic to major stores, then you're at higher risk.**

One of the variables that helps the app achieve that level of granularity is crowd-sourced data, which it gathers when users download the SafeDistance app and enter anonymous demographic and health data, such as whether they've been displaying symptoms of COVID-19, have had contact with infected people or have been clinically diagnosed with the disease. The app also incorporates officially reported cases at the county level, population density information, and a data set that measures foot traffic in major retail stores, according to Brian Krohn, Ph.D., a developer at the software company Modern Logic and technical lead on the project.

That health and geographic data is then displayed in a color-coded heat map by neighborhood to indicate areas where COVID-19 is likely circulating, giving users insight about whether they should practice social distancing or self-isolation in response. "Basically, if you're in an area that has lots of COVID, you're in a high-density neighborhood, and there's lots of foot traffic to major stores, then you're at higher risk," Krohn explains. HealthPartners promoted the app to its 25,000 employees, and about 50,000 neighborhoods over the past month have reported some data, he says.

Creators Are Still 'Building the Airplane'

Krohn tells AIS Health that he and his team built the app in just under a month, "mostly bootstrapped with volunteer developers," after observing that the U.S. needed a better way of helping people assess their risk for a coronavirus infection.

"We've been pretty much doing continual improvements, building the airplane as we're flying it," he adds. As part of that evolution, Krohn is aiming to build functionality into the app that goes beyond assessing people's current risk of contracting the virus.

"We see a core area where there's lots of reported cases, and then a halo around that of people who are reporting symptoms, and then a halo around that of people that are reporting that they may have been exposed to someone with symptoms or a confirmed case," he explains. "So the hope is that we can turn that into more of a predictive model to identify where it is spreading."

Contact Byers via Anthony Matrisciano at anthony.matrisciano@highmarkhealth.org, Krohn via David Martinson at david.p.martinson@HealthPartners.com and Regan via Allessandra Skinner at ali.skinner@cdphp.com. ✧

by Leslie Small

SUD Treatment Goes Remote

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The federal government has made moves to facilitate SUD treatment via telehealth while patients are self-isolating. They include changes in reimbursement rules for virtual or telephonic behavioral health visits, Centers for Disease Control and Prevention guidance designed to facilitate virtual support meetings, and new regulations that allow providers to prescribe initial buprenorphine therapy for opioid patients remotely. (Starting a new patient on methadone still requires an in-person visit.)

However, as Blanco explained, the lack of data means there is a fly-by-night quality to SUD treatment during the pandemic. Providers and payers are being forced to provide treatment that may not work, and patients may not know they can use the new modalities.

Blues Plan Sees Lower Use of Treatment

Arkansas Blue Cross and Blue Shield has seen reduced utilization of SUD treatment during the pandemic, despite the payer taking measures to improve access, including waiving cost sharing for in-network SUD treatment.

"For inpatient and partial and residential [SUD treatment], we've had about a 12% decrease during the COVID-19 pandemic of people being admitted to behavioral health facilities and substance use disorder facilities," said Arkansas Blue Cross and Blue Shield Corporate Medical Director Herbert Price, M.D., during the NIHCM webinar. Price said the plan has tried to facilitate remote and outpatient SUD treatment for members who would worry about entering an inpatient facility during the pandemic.

"We've expanded outpatient substance use disorder treatment [and] we

opened up some telephone codes that we'd never covered before as a plan," Price added. "We opened up telemedicine to substance use treatment order providers…the telemedicine codes that were opened up have always been in existence, but we removed a lot of the requirements."

A slide deck accompanying Price's presentation indicated that Arkansas Blue Cross Blue Shield's telemedicine behavioral health visits, which includes but is not exclusive to SUD treatment, increased from practically no visits in February to nearly 14,000 in April.

"There's an increase, as we went to telemedicine, in [telemedicine] services provided to opioid and stimulant use disorder [patients] that was not there when it was primarily office-based visits. So this has increased [telemedicine] access to this population during the COVID-19 crisis," Price said.

Still, commercial plans are only part of the picture. Jerry Vitti, CEO of Healthcare Financial, Inc., is worried that the Medicaid population does not have access to high-quality telehealth SUD care. According to a 2015 report by the federal Medicaid and CHIP Payment and Access Commission, Medicaid plans are the largest provider of behavioral health and SUD treatment nationally. Vitti says telehealth SUD

Academy of Actuaries Report Sizes Up Federal Options to Deflect Insurer Risk

Though COVID-19 has put significant pressure on the health care system at large, payers have not yet felt the financial pain confronting hospitals, since utilization for chronic and elective care is at unprecedented lows. But an anticipated spike in utilization *(HPW 5/11/20, p. 4)* as stay-at-home restrictions relax has led some in the health policy community to examine how the federal government might help mitigate that risk.

According to a May poll conducted by the Kaiser Family Foundation, 48% of Americans have skipped or postponed medical care due to the pandemic, and 32% of that group say they will seek to resume their care in the next three months. Among the people who delayed care, 11% reported their condition worsened because of the delay. That pent-up demand could combine with some level of ongoing need for care to drive claims above anticipated 2020 amounts.

That impending resurgence has opened up discussion about some sort of federal guarantee for insurance firms' solvency. A May 18 issue brief released by the American Academy of Actuaries concluded that:

- ***A one-sided federal risk corridors program would protect payers from "unusually large" financial losses***, while two-sided risk corridors would do the same and guard against "unusually high" insurer gains;
- ***Reinsurance can protect payers from risk*** associated with high-cost enrollees, regardless of whether they faced unexpected losses; and
- ***Medical loss ratio requirements could "provide a backstop*** on unanticipated insurer gains under either one-sided risk corridors or reinsurance."

However, the report's primary author, American Academy of Actuaries senior health fellow Cori Uccello, emphasized that such programs won't solve every health care finance problem created by the pandemic. "Depending on how they are structured, risk mitigation mechanisms such as risk corridors could help with the increased uncertainty health insurers face due to COVID-19. But they won't address other risks in the health system such as declining provider revenues and increased pressures on state Medicaid programs," Uccello said in a press release.

David Anderson, a research associate at the Duke University Margolis Center for Health Policy, argues that policymakers should focus on safety net programs unless commercial carriers are in deep financial trouble.

"In my opinion, it should only be triggered if it's truly catastrophic," Anderson tells AIS Health. He says that self-insured plans carry larger risk than the rest of the commercial insurance industry, but that "most of the actuaries are fairly convinced that the 2020 premiums are more than sufficient to cover 2020 claims."

Read the report at https://bit.ly/3d4K9KS and the KFF poll at https://bit.ly/2ZN2mZN. Contact Anderson at david.m.anderson@duke.edu and Uccello via David Mendes at mendes@actuary.org.

by Peter Johnson

treatment is far behind telehealth treatment in primary care.

"The need is crying out for telemedicine. It's not anywhere near where it is in primary care. It's not as available, period, and the rate of adoption is slower, while you have this kind of exploding need. There's a technology and a treatment gap that's growing," Vitti tells AIS Health.

"The quality of [SUD] care is largely dependent on continuously following up with folks," Vitti says. "For folks with barriers, that's especially hard. You have to figure out how to connect with them. In normal times, it's hard to figure out how to connect with folks who have these dependencies. In these times, where there's less face-to-face, there's more need in the community [for follow-up care]. And unfortunately, the gap is growing between the need and the provision of telemedicine."

Basic continuity of care is something that providers and payers can start doing immediately, according to Abner Mason, CEO of ConsejoSano, a health care tech startup that provides culturally competent and multilingual patient communications. ConsejoSano identifies and contacts patients via phone and text on behalf of contracting providers and payers.

"We've been able to generate, over the last eight weeks or so, 35,000-plus telemedicine visits for safety net providers," Mason tells AIS Health, including a large number of behavioral health visits.

As Vitti observed, follow-up care is an obvious use case for remote SUD treatment, and so far it is the most studied area of remote SUD treatment. However, leading researchers in the field agree with Blanco's assertion that moving remote treatment from a supplementary role to a central one is an unprecedented test.

"[Telehealth SUD treatment has] been conceived as aftercare [and] supportive treatment," says Andrew Quanbeck, Ph.D., an assistant professor at the University of Wisconsin-Madison. Quanbeck is a systems engineer who studies technological implementation for health care providers and is the co-author of several peer-reviewed papers on SUD care via mobile apps. "For the most part, it hasn't been envisioned or designed to be a replacement for what's usually the more in-person, intensive kind of treatment regimen that most addiction treatment starts out with," he says.

Quanbeck tells AIS Health that he's confident telehealth can play a leading role in follow-up care, but he's uncertain about how effective the modality will be as the star.

"It is accurate that what we're doing is a massive natural experiment on a large scale to take parts of what's traditionally been the in-person elements of treatment and move it to telehealth. So as a researcher, my standards for evidence are pretty high, and we are in pretty uncharted territory in terms of knowing whether you can, this quickly, switch from in-person modality to telehealth and expect it to have the same effectiveness," Quanbeck explains.

According to Kevin Hallgren, Ph.D., a clinical psychologist and a researcher at the University of Washington's Behavioral Research in Technology and Engineering (BRiTE) Center, practitioners face an array of challenges in adapting SUD treatment to a telehealth modality. Hallgren has

Total Compensation for Publicly Traded Health Insurer CEOs in 2019

Company	CEO	Total Annual Compensation 2019	2018	Full Year Increase or (Decrease)
Centene Corp.	Michael Neidorff	$26.44 million	$26.12 million	1.2%
Humana, Inc.	Bruce Broussard	$16.73 million	$16.31 million	2.6%
UnitedHealth Group	David Wichmann	$18.89 million	$18.11 million	4.3%
Anthem, Inc.	Gail Koziara Boudreaux	$ 15.47 million	$14.18 million	9.1%
Cigna Corp.	David Cordani	$19.30 million	$18.94 million	1.9%
Molina Healthcare, Inc.	Joseph Zubretsky	$18.03 million	$15.22 million	18.5%
Triple-S Management Corp.	Roberto Garcia-Rodriguez	$4.19 million	$3.25 million	28.9%

NOTE: WellCare Health Plans, Inc. is excluded from this list because it was acquired by Centene Corp. in 2019 and thus did not submit executive compensation data to the Securities and Exchange Commission.
SOURCE AND METHODOLOGY: Compiled by AIS Health from company financial statements. Total compensation includes base salary, bonuses, stock awards, options/stock appreciation right (SAR) awards, non-equity incentive plan compensation, non-qualified deferred compensation earnings and all other compensation.

researched the integration of mobile technology with behavioral health treatment, including SUD treatment.

Hallgren says the wide variety of SUD treatment settings present unique challenges in the move to remote treatment, as do the nuances of treating a patient with a specific dependency: opioids require a different approach than alcohol, for example.

"There are many types of substance use treatment settings. There are many types of SUD treatment patients — finding the right match for the right person at the right time in the right setting is a very complicated thing," Hallgren tells AIS Health.

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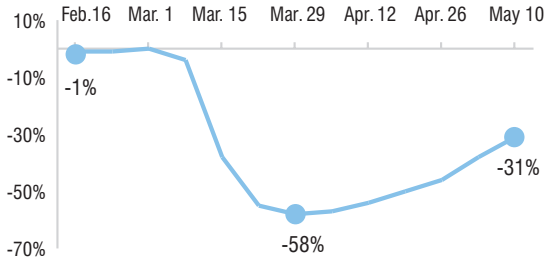
Outpatient Visits Rebound, Yet Remain a Third Lower Than Before COVID-19

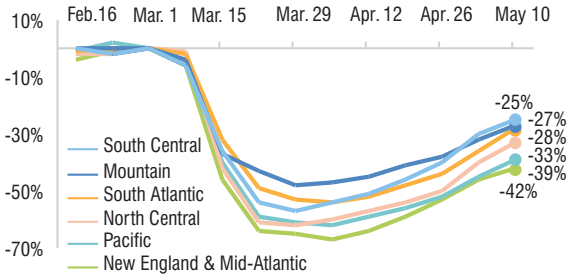
by Jinghong Chen

The number of visits to ambulatory care practices has rebounded since April after a 60% drop in mid-March *(HPW 05/18/20, p. 7)*, according to a recently updated analysis by researchers at Harvard University and health care technology company Phreesia. The visit rebound occurred across the nation, but the South Central census division — Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee and Texas — saw the greatest growth. The number of telehealth visits rose dramatically during the height of the pandemic, accounting for 14% of total outpatient visits during the baseline week of March 1-7, but have decreased slightly since mid-April. The decline in outpatient visits remained largest among surgical and procedural specialties and pediatrics.

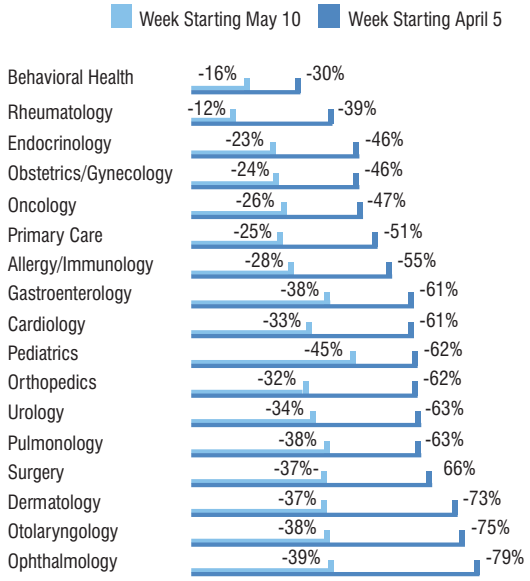
Percent Change in Visits to Ambulatory Practices From Baseline Week (March 1-7)



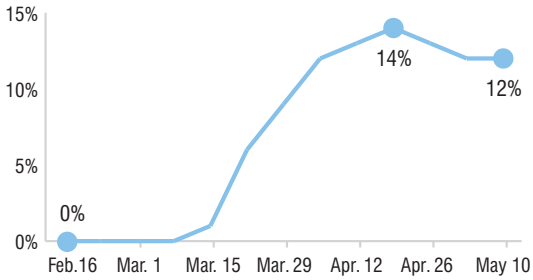
Percent Change in Visits to Ambulatory Practices From Baseline Week (March 1-7), by Region



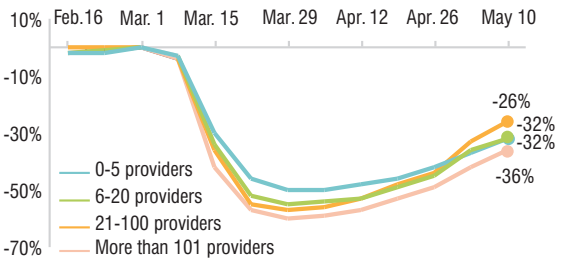
Percent Change in Visits to Ambulatory Practices From March 1 to May 10, by Specialty



Number of Telehealth Visits as a Percent of Baseline Total Visits



Percent Change in Visits From Baseline Week (March 1-7), by Provider Organization Size



SOURCE: "The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges," The Commonwealth Fund, May 2020. Visit https://bit.ly/3d9YhCG.

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"There is, not that I know of, a one-size-fits all recommendation that I can offer. I don't think there's a specific app — or even class of apps — that I could say, 'this is the way to go.'"

Thus, Hallgren worries that the health care industry could make a mistake by moving too quickly toward unproven telehealth services during the pandemic. "All of a sudden [telehealth SUD treatment has] been required. We have to do it. And so people are trying their very best to make it work, and they're having some success and some challenges," Hallgren says. "We may go back to more in-person, face-to-face treatment, but we know that certain things are now very viable to do remotely…When social distancing is over, we're going to have another time to figure out what we're keeping." And while health plans will check that providers took the necessary steps to bill for remote SUD services, that "is different than saying what works clinically," he adds.

But Quanbeck says making a switch to telehealth SUD treatment is necessary during the current crisis. "The pandemic is obviously forcing things out of necessity," Quanbeck says. "I think that you can make a reasonable case that telehealth is likely better than doing nothing and leaving people completely on their own for months at a time. So I think it's definitely the right thing to do."

Find the NIHCM webinar at https://bit.ly/2yKevn6. Read federal guidance for SUD telehealth visits at https://bit.ly/2Ma5gzH and buprenorphine and methadone provision at https://bit.ly/2ZKWeBd. Contact Mason and Vitti via Joe Reblando at joe@joereblando.com, Hallgren at khallgre@uw.edu and Quanbeck at arquanbe@wisc.edu. ✧

by Peter Johnson

News Briefs

✦ ***Some health insurers received and then returned unsolicited payments from the $30 billion grant fund that HHS distributed to offer COVID-19 financial relief to health care providers, Modern Healthcare reported.*** UnitedHealth Group received and returned $49 million, Cigna Corp. returned $41 million, and CVS Health Corp., which owns Aetna, received and returned $43 million. Humana Inc. and Centene Corp. also told Modern Healthcare that they returned some relief funding, though they did not disclose how much. Read the article at https://bit.ly/2Xa9FZv.

✦ ***CVS Health Corp. is being sued by six Blue Cross Blue Shield plans that claim CVS "intentionally engaged in a fraudulent scheme" to overcharge them for prescription drugs by "submitting claims for payment at artificially inflated prices."*** The lawsuit claims CVS "intentionally told third-party payors, including Plaintiffs, that the prices charged to cash customers for ...generic drugs were higher — often much higher," than they actually were. "Third-party payors then reimbursed CVS based on those higher, inflated prices — instead of the actual, lower, prices CVS offered to the general public, including through its Cash Discount Programs." CVS is disputing the claims. View the lawsuit at https://go.aws/36FfpO5.

✦ ***Cigna Corp. on May 27 launched a program that gives its employer clients access to a debit card with pre-loaded funds that employees can use for "qualified disaster relief payments," including medical payments, groceries, child care and wellness services.*** Payments made via the Cigna Care Card are both tax-free to employees and fully deductible to the employer, according to the health insurer. Read more at https://bit.ly/2M6iuxj.

✦ ***A new study, published in the journal JAMA Internal Medicine, adds to a growing cadre of research questioning the effectiveness of workplace wellness programs.*** The randomized clinical trial of a wellness program for employees of the University of Illinois at Urbana-Champaign concluded that the program had no significant impact on participants' measured physical health outcomes, rates of medical diagnoses or their use of health care services after 24 months. However, it did increase the proportion of employees reporting that they have a primary care physician, and it "improved employee beliefs about their own health." Find the study at https://bit.ly/3erx0M5.

✦ ***Fifty-five percent of primary care clinicians surveyed by the Primary Care Collaborative from May 15-18 said they're unprepared for the next wave of the coronavirus pandemic.*** Respondents cited reasons including "high stress among clinicians, limited access to testing and adequate [personal protective equipment], and patient struggles with technology." Contact Stephen Padre at spadre@thepcc.org.