



*The Health Alliance of Northern California (HANC) and the North Coast Clinics Network (NCCN) are regional associations of community health centers who annually serve more than 200,000 patients across 14 rural, northern California counties.*

## Addressing the COVID-19 Pandemic in Rural California

### The Power of Community Health Center Collaboration

#### Overview

Northern California's rural community health centers (CHCs) faced consecutive public health emergencies over the last several years. In 2020 these CHCs concurrently contended with the COVID-19 pandemic and the wildfires. During this unprecedented period of co-occurring emergencies, ensuring access to health care was their priority. The focus of this paper will be to highlight 1) ongoing health care inequities in northern California's rural areas, which CHCs encountered prior to the COVID-19 pandemic; 2) logistical challenges CHCs met in providing care during the 2020 COVID-19 pandemic; 3) collaborative strategies used to address these COVID-19 obstacles; and 4) needed immediate solutions, considering pre and post COVID-19 health challenges.

#### Rural Health Disparities

Rural residents are more vulnerable to severe illness or death from COVID-19 than urban residents because of factors such as underlying health problems, older age, lack of health insurance, and difficulty accessing medical care.<sup>i</sup> This health outcome disparity is consistent with past rural health data, as rural populations have a poorer health status compared with urban populations.<sup>ii</sup> The difference seen in COVID-19 outcomes is thought to be in part a result of social determinants of health, like geographic isolation, an aging population, limited post-secondary education opportunities and employment prospects. The health disparity is also due to a rural maldistribution of clinical health workforce, which is evidenced by a patient-to-primary care physician ratio in rural areas that is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.<sup>iii</sup> Because a

greater supply of primary care physicians is associated with lower mortality,<sup>iv</sup> it is unsurprising, then, that mortality and poor health outcomes correlate with levels of rurality.<sup>v</sup>

Pre-pandemic health workforce data suggests that the national, rural health workforce shortage will worsen as physicians in rural areas age out of practice. The rural physician supply is projected to decline 23% by 2030, with "nearly all the forecasted decline" due to a reduction in the number of rural physicians 45 years of age or older.<sup>vi</sup>

Local data tells a similar story. A 2016 Shasta County Physician Workforce Assessment<sup>vii</sup> found that of physicians practicing in Shasta County:

- 51% were found to be over 56 years of age.
- 20% of those 56 or older indicated that they may retire or relocate in the next five years.

#### COVID-19 Challenges

**Staffing Needs**—As COVID-19's lethality became understood, CHCs had to quickly consider the safety of their medically "high-risk" staff, particularly during the beginning weeks of the pandemic when personal protective equipment (PPE) was in shortest supply. Rural communities are disproportionately older, and so is their clinical workforce. Therefore, many of HANC's and NCCN's (the "Consortia") member CHCs allowed their high-risk staff to stay home, or work from home when possible. CHCs also attempted to grant employee requests to stay home due to pandemic-related home-life demands; one clinic reported that more than 40% of its workforce had

requested time off to address childcare and family needs. Many CHCs were, therefore, unable to operate at needed capacity due to leave requests, an issue that was exacerbated with an already limited workforce.

*Employee Leave*—CHCs reported that employees were exhausting their COVID-19 leave. In response, some CHCs attempted to implement childcare solutions to offset their anticipated staffing shortages from school closures and to help employees that had already expended available time off.

*Decreased Demand for Routine Care*—Once public fear of the virus grew, consumer demand for routine medical services declined. Just as CHCs had to grapple with the operational uncertainty presented from staff wanting or needing to stay home, CHCs were also forced to consider the implications to their organizations of a reduction in more than 50% of their medical visit volume. Leaders were then left to decide which of their clinical sites to keep open, and which of their employees to furlough or layoff, while simultaneously contending with perennial shortages of other types of personnel. For example, CHCs reported that front office staff were requesting — themselves—to be laid off for various reasons. CHC leaders voiced serious concerns about what these temporary changes would ultimately mean for their long-term staffing.

*COVID Testing*- As COVID-19 transmission continued to rise across the state, and later throughout the rural region, so did delays in COVID-19 test results. For months, test results took 7-14 days. The most rural communities without immediate access to state-sponsored testing sites, or county public health labs, experienced the longest delays. These testing delays meant that CHC employees who may have been exposed (onsite or otherwise) would be out from work for an extended period as they awaited results. Organizations reported that 10%-15% of their needed workforce could be out at any given time. One CMO reported bluntly that the biggest impact from COVID-19 testing delays to her organization was on staffing.

*Community Surveillance Testing*—When testing supplies became available, some CHCs began assisting counties with community surveillance testing,

especially in outlying areas where counties were under resourced. CHCs in these outlying areas, however, reported that their organizations were understaffed to meet the overall community demand for testing.

*Enforcement of Public Health Measures*—Not only did CHC organizations need to encourage some of their own employees to adhere to social distancing and masking recommendations, other CHC employees were required to enforce the same policies with patients and community members who ignored public health guidelines. These patient interactions were reported as contentious, and additionally stressful for staff. One organization reported the need to hire a security presence at each of its sites to ensure employee safety.

*Wildfires*-Concurrently, active fires throughout the region began to affect CHC operations and staffing. With these parallel emergencies, organizations needed to navigate staff evacuations from their homes, additional site closures, and further delays to testing. Throughout the wildfire season, CHCs reported staff stress from significant wildfire smoke, evacuations, power outages, and other fire-related traumas that accrued over the last several years.

*Racial Justice Protests*—When racial justice protests swept the country after the death of George Floyd, CHCs reported that community tensions also began to rise beyond the stress of the pandemic and wildfires. At multiple sites employees expressed sadness, anger, and “concern for the state of the country.” Confrontational protest-backlash reportedly spilled over into some clinics with expressions of anger and racism directed at CHC employees.

<b>Figure 1. COVID-19 Challenges in Summary</b>	
<ul style="list-style-type: none"> <li>• Staffing needs</li> <li>• Employee leave</li> <li>• COVID-19 testing</li> <li>• Community surveillance testing</li> </ul>	<ul style="list-style-type: none"> <li>• Enforcement of public health measures</li> <li>• Wildfires</li> <li>• Racial justice protests</li> </ul>

## COVID-19 Response—The Power of Collaboration

Though CHCs faced many challenges, they were able to work together, share best practices, and navigate the public health emergencies using the following strategies:

*CHC Peer Networking*—As a function of their Consortia memberships, CHC leadership (CEOs, CFOs, CMOs, COOs, QI and other staff) attended weekly collaborative meetings over the course of the pandemic. During these discussions, leaders were better able to anticipate future challenges, problem solve, and share resources and best practices. This collaboration also allowed the Consortia to facilitate and coordinate resources between shared county and state partners. Members stated that the regular meetings provided needed support and timely information. Some of the issues discussed are included in Figure 2 below.

Figure 2. Topics Addressed During CHC Peer Network Meetings	
<ul style="list-style-type: none"> <li>Managing visit volume with SIP orders</li> <li>Shift to telehealth and billing</li> <li>Homeless population support</li> <li>PPE-need, purchase and burn rate</li> <li>Staffing-layoffs and rehires</li> <li>Creation of Federal Medical Stations</li> <li>Masking</li> <li>Testing at CHCs and in the community</li> </ul>	<ul style="list-style-type: none"> <li>Early release of prisoners</li> <li>Working remotely</li> <li>Staff morale</li> <li>COVID-19 resource spending</li> <li>SBA loans</li> <li>Re-opening counties</li> <li>Exposure control plans</li> <li>Teledentistry</li> <li>Contact tracing</li> <li>Employee holiday travel</li> <li>Community outbreaks</li> <li>Managing COVID + Staff</li> </ul>

The following issues are worth highlighting in more detail:

*Telehealth*—In March 2020 then President Trump declared the coronavirus pandemic a national emergency. Following his declaration, California was able to temporarily implement broad telehealth allowances (including for telephonic/audio-only care) in the state’s Medicaid (Medi-Cal) program.<sup>viii</sup>

These flexibilities, among other things, allowed CHCs to utilize telehealth in novel ways. In response to the

new telehealth flexibilities, most CHCs moved to adopt these new care modalities quickly and widely. Because of weekly leadership meetings, CHCs were able to share best practices to redesign workflows for successful adoption. Organizations reported that adopting telehealth improved the operational workload on support staff, which was helpful to CHCs who simultaneously were working to backfill their most impacted positions. Ultimately, telehealth adoption assisted CHCs in dramatically reducing no-show rates and returning to about 70%-80% of their pre-pandemic visit volume, despite the current strain on staffing. The Health Resources and Services Administration (HRSA) reported that telehealth accounted for 50% of CHC visits, nationwide.

*Staff Morale*- Managing employee fear and stress became a recurring need for CHC leadership. CHC CEOs were often concerned about the cumulative trauma their employees had to endure between past and current wildfires, a new pandemic, and social justice protests and counter protests. One large CHC administered an anonymous organization-wide survey regarding COVID-19 stress. With a 60% response rate, the survey indicated that staff expressed an abundance of fear, family and childcare worries, and depression. A small number of employees surveyed indicated suicide ideation. In response to this type of employee stress, organizations implemented various staff morale programs. For example:

1. One CHC offered voluntary mental health check-ins with an outside facilitator, either in groups, or 1-on-1, which were meant to allow CHC staff to debrief about their experiences in a safe setting. The program was reportedly valued.
2. The Consortia, in partnership with the California Primary Care Association (CPCA), hosted a provider well-being training for CHC mid-levels and physicians entitled, "A Fierce Heart: Cultivating Compassion as a Capacity for Provider Well-Being". Feedback from participants was positive.

*Temporary Workforce*—Unable to find permanent staffing to help meet the care demand, some CHCs were required to hire temporary clinical staffing (locums) to offset COVID-19 testing. Additionally, CHCs hired temporary, clinical respiratory staff. While some

CHCs reported that these temporary hires were helpful in offsetting their organizations' workloads, this type of temporary staffing came at a higher financial expense at a time when CHC revenue was relatively unpredictable.

*Collaboration to Address Communitywide Pandemic Issues*—Throughout the rural region, the Consortia facilitate various local health collaboratives between their CHC members and their community partners. During the pandemic, the Consortia were able to facilitate several of these collaborative meetings, which comprised topics such as surge planning for hospitals, CHCs and the County and planning for field station hospitals in Redding and Eureka. Issues identified from these meetings were also communicated to elected officials and other stakeholders.

### **Moving Forward**

While long-term, systemwide changes are sorely needed in health care, shorter-term solutions will also help CHCs manage current and future public health emergencies. We therefore implore policy makers, elected officials, and the philanthropic community to help effectuate the following recommendations:

#### ***Recommendation #1***

##### ***Invest in collaboration to improve health care delivery***

The value of a local and trusted organizing group to help maintain and improve public health cannot be understated. The Consortia's role in coordinating CHCs and their partners during the pandemic was crucial to achieving an organized and effective response. Because the Consortia were able to utilize existing communitywide relationships, health stakeholders were able to quickly problem solve with one another.

The value of collaboration to improve health care delivery is not limited to times of emergency. As the State moves forward to redesign the Medicaid system, through initiatives such as CalAIM, more partners will need to work together to obtain cost savings and ultimately improve health outcomes. Currently, the degree of local collaboration varies in northern California. Efforts should be supported to replicate collaborative efforts throughout the region.

#### ***Recommendation #2*** ***Expand scopes of practice***

Early anecdotal evidence suggests that COVID-19 has hastened retirements or encouraged a reduced practice load for older clinicians. To assuage the current clinician supply, strategies that can help avoid an accelerated shortage should be prioritized. These strategies should include longer-term efforts, like payment modernization, and shorter-term strategies like expanding scopes of practice when evidence supports the expansion. Current California restrictions on the kinds of practitioners able to serve patients in a CHC setting are outdated. For example, "Other states have removed restrictions that visits have to be with a physician, nurse practitioner, or physician's assistant."<sup>ix</sup> If a visit then could occur in, for instance, some type of group setting, as opposed to one-on-one, and be led by a peer counselor, as opposed to a physician or nurse practitioner, access to services would improve for patients. Furthermore, the pool of allied health workers available to offset the current demand burden on clinicians would increase.

#### ***Recommendation #3***

##### ***Extend current telehealth (and telephonic) flexibilities in the Medicaid program***

Prior to the pandemic, CHCs were not as able to be reimbursed for telehealth.<sup>ix</sup> Once the pandemic became a reality, however, and in response to the State allowing CHCs to start billing for these services (including audio-only/telephonic care), CHCs quickly developed the needed competencies and infrastructure to utilize the technology. Currently lawmakers and health care stakeholders are debating questions regarding the rationale behind a permanent adoption in California of the kinds of new telehealth flexibilities implemented during the pandemic. For example, when and how is a telehealth visit of the same quality as an in-person visit? Or how does telehealth affect overall access to and utilization of services and what does that mean in terms of cost? From a health care workforce perspective, though, the argument for widespread telehealth adoption is clear.

Telehealth provides the opportunity to deploy numerous strategies that ultimately can help maintain current access to services, which is especially important in rural areas where the rural physician

supply is expected to decline 23% by 2030. It is also important to recognize the necessity of telephonic care in rural areas, considering the disparity that exists in rural broadband access.<sup>x</sup> “If telehealth can encourage existing providers to work more hours from home, or encourage retired providers to return to practice, it can have a significant effect,”<sup>xi</sup> according to a recent RAND Corporation telehealth analysis.

#### ***Recommendation #4***

##### ***Remove restrictions for Same Day Billing***

The COVID-19 pandemic has shed light on numerous health care delivery reforms needed in the future. For example, CHCs are beholden to an antiquated payment system that even prior to the pandemic needed change. Considering the pandemic, these old rules present obstacles to CHCs providing optimal patient care and being ideally staffed. CHCs’ widespread adoption and utilization of telehealth demonstrates that if these safety-net organizations are provided the flexibility to respond to a community need, even in the face of disaster, CHCs will do everything they can to meet the need.

Beyond telehealth, one commonsense way to improve access to needed services, while making the delivery of care more efficient for CHC staffing and for patients, would be to remove restrictions on community CHCs for same-day medical and behavioral health visits. Because CHCs are only able to bill for one (medical and/or behavioral health) visit per patient, per day, a patient who may need both types of visits would need two appointments on different days. Not only is the restriction a possible deterrent to patients seeking care, but it is also operationally inefficient, and an unnecessary burden on CHC staffing.

#### **Conclusion**

Continued investments in community health collaboration will help northern California’s rural areas implement needed policy changes—like payment modernization, and health care system redesign—and help health care stakeholders be ready and able to effectively navigate future public health emergencies. Our rural region’s ability to navigate an emergency like the COVID-19 pandemic should not only be of concern to these area’s residents, but to lawmakers, policy makers and the public at large because, “given that, as compared with more urban populations, rural

residents are likely to be older and poorer, are more commonly uninsured, and have lower life expectancy.”<sup>vi</sup> With more than 4 million people living in the state’s rural areas,<sup>xii</sup> and the availability of primary care clinicians in rural areas on the decline,<sup>xiii</sup> targeted investments to evolve the health care safety net and improve primary care clinician supply should be considered—among other things—an urgent matter of public health.

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