



EMORY

Atlanta
Long COVID
Collaborative

Atlanta Long COVID Collaborative

Atlanta, Georgia

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PROGRESS

Reduced care barriers by improving referral pathways and strengthening connections between community members, healthcare providers and Long COVID clinics.

INNOVATIONS

- Implemented multidisciplinary case conferences to provide expedited comprehensive care and mitigate unnecessary referrals
- Launched behavioral health group therapy sessions to build community and peer support
- Formed a multidisciplinary, national group of Long COVID clinicians to discuss treatment approaches, share knowledge and develop a consensus statement based on our work

COMMUNITY IMPACT

- Partnered with local health departments and patient-led organizations to expand access and increase awareness
- Implemented changes to clinic operations and workflow to meet needs of our community based on patient focus group evaluations



"We are grateful to AHRQ for acknowledging this critical need and for investing in the health and well-being of individuals heavily impacted by Long COVID."

— Tiffany Walker, M.D., Principal Investigator

This project aims to expand access to evidence-based, comprehensive Long COVID care across Georgia's metropolitan areas and beyond by implementing a person-centered coordinated care model that meets the needs of patients, families, clinicians and advocates.





Johns Hopkins Post-Acute COVID-19 Team (JH PACT): Supporting Patients Recovering from COVID-19 (SPaRC)

Baltimore, Maryland

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[hopkinsmedicine.org](https://hopkinsmedicine.org/coronavirus/pact)

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PROGRESS

Implementation of key integrated services for Long COVID (LC) patients:

- Clinical pharmacy care
- Behavioral health (psychiatry liaison and rehabilitation psychology)
- Neuropsychological assessments
- Speech-language pathology for cognitive symptoms
- Licensed clinical social work
- Physical therapy with LC expertise
- Community health worker for social resources

INNOVATIONS

- LC support program (ongoing monthly meetings and upcoming training for peer supporters)
- LC education for mental health providers

COMMUNITY IMPACT

Regional impact with referrals from rural and urban areas throughout the mid-Atlantic and Northeast (~3,000 PACT encounters with multidisciplinary team over 12 months)

SPaRC TEAM



"Through working with the PACT clinic, with Long COVID aware providers, I was able to obtain testing, diagnosis and treatment...that has improved my quality of life and...ability to work."

— JH PACT Clinic Patient



OVERVIEW

SPaRC builds on the existing interdisciplinary JH PACT program to deliver comprehensive LC care with the following goals:

- increase capacity to serve more patients
- expand clinical services to key populations, e.g. older adults and those in rural areas
- partner with organizations and primary care networks across the mid-Atlantic region to enhance clinical care
- provide LC education for primary care providers
- engage stakeholder advisory council to regularly inform implementation and refinement of SPaRC



Kennedy Krieger Institute Long COVID Care Network

Baltimore, Maryland

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[Pediatric Post-COVID-19](#)

[Rehab Clinic webpage](#)

PROGRESS

We have transformed our clinic with a dedicated nurse educator/coordinator to facilitate healthcare navigation for children and families and conducted three pediatric Long COVID ECHO series for providers.

INNOVATIONS

- Developed an effective, novel telementoring program for pediatric Long COVID (see right panel)
- Developed family/community resources
- Developing school navigation roadmaps

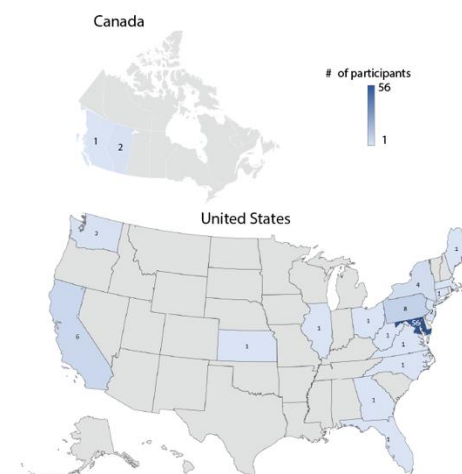
COMMUNITY IMPACT

- Improved awareness of pediatric Long COVID
- Improved access and navigation of care for children and their families



This project aims to improve access to care for children with Long COVID by expanding Kennedy Krieger Institute's multidisciplinary rehabilitation clinic to include integrative healthcare approaches and school-based support resources. Additionally, it will develop a telementoring ECHO program to train community providers across Maryland and the Mid-Atlantic region in diagnosing and managing pediatric Long COVID, with special focus on children with disabilities and those in rural or underserved areas.

Long COVID ECHO Participants



Our telementoring ECHO program engaged 94 clinicians from across the United States and Canada (figure above; 17 states and 2 provinces). We showed a significant and meaningful improvement in knowledge, confidence, competence and self-efficacy of participants in the ability to diagnose and treat pediatric Long COVID.

PMID: 40077880



St. Louis Long COVID Initiative

St. Louis, Missouri

PIs: Abby Cheng & Amy McQueen, WashU Medicine

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PROGRESS

- Created timely access to Long COVID behavioral health care, peer support and connection to community resources

INNOVATIONS

- Improved financial and geographic access to Long COVID rehabilitation:
 - Shared medical appointments
 - Instructional videos, website

COMMUNITY IMPACT

- Presentations to 35 clinical care teams and medical conferences
- Community outreach at 20+ health fairs and 220+ community events



PROJECT AIMS

- Expand access to Long COVID care
- Improve the Long COVID care experience
- Support primary care teams in caring for patients with Long COVID

“My life was completely changed once [Long COVID] physical therapy and occupational therapy came into my life. They gave me a 110% chance of having my life back — and I will forever be grateful for that.”

— Emily, patient of the WashU Long COVID Clinic





Colorado Multidisciplinary Translation Network (CO-MTN)

Aurora, Colorado

PIs: Donald Nease and Sarah Jolley, University of Colorado Anschutz

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CO-MTN Team

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PROGRESS

- Recruitment of 20 primary care clinics to pilot integrated care network
- Employee and patient interviews/surveys
- Primary care-based ECHO asynchronous and live series

INNOVATIONS

- Creation of PCP Long COVID one-pager
- Creation of EPIC dot phrase template for providers

COMMUNITY IMPACT

- Lt. Governor and a participating MDC hosted a Long COVID roundtable to advance Long COVID care and collaboration



"The Long COVID CO-MTN project demonstrates a coordinated model of care through structured navigation and collaborative practice support that strengthens connections between primary and specialty care. To successfully implement our project, we have leveraged health and nurse navigators to provide proactive appointment coordination, community resource linkage and health-related social needs screening, while primary care-based practice facilitators drive uptake and implementation of our tiered care model, through supporting workflow optimization and cross-setting communication. Together, these integrated strategies can sustainably improve care delivery not only for Long COVID, but for other complex chronic conditions, as well."

— Marissa Morales, Health Navigator

AIMS

- Increase access to Long COVID care by streamlining care processes between multidisciplinary and primary care clinics
- Expanding impact and reach to Long COVID patients across Colorado



Mount Sinai Internal Medicine Associates (IMA) Long COVID Care Network

New York City, New York

MPIs: Juan Wisnivesky, Alex Federman, The Mount Sinai Hospital

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PROGRESS

- Provided care for more than 500 patients, including those from communities disproportionately impacted by COVID-19
- Provided lectures on Long COVID care to 240+ medical residents and faculty-level clinicians within and outside Mount Sinai practices

INNOVATIONS

- Primary care-integrated Long COVID practice designed to facilitate continuity of care and seamless communication between specialists and primary care providers
- Primary care-based comprehensive neuropsychological evaluations; over 60 evaluations completed to date

COMMUNITY IMPACT

- Partnered with 25 community-based organizations to educate residents on Long COVID symptoms and available resources
- More than 70 education/community outreach events to date



We provide specialized medical care for adults with Long COVID in a primary care setting to improve access to and continuity of care, with a focus on reaching patients in communities that have experienced high rates of COVID illness.

“When I entered the Mount Sinai IMA Long COVID Clinic in December 2020, it was the first time I felt truly seen, believed and validated. The care I received went beyond medical treatment. The team combined rigorous research with compassion, humanity and deep respect for patients navigating an invisible illness.”

— Patient, Mount Sinai IMA Long COVID Clinic



Pitt (IMPACCT) Long COVID Care Access and Treatment Program

Pittsburgh, Pennsylvania

PIs: Frank C. Scieurba, M.D., FCCP; Alison Morris, M.D., M.S.; Howard B. Degenholtz, Ph.D.; University of Pittsburgh

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PROGRESS

- Produced three foundational Long COVID education modules for dissemination to family medicine providers via online platform
- Developed electronic health record tools to optimize efficiency and education, and to augment appropriate testing, treatment and referral

INNOVATIONS

- Developed methods to monitor program effectiveness through patient surveys using an algorithm to identify patients with Long COVID based in the electronic health record

COMMUNITY IMPACT

- Delivered educational materials and organized three community outreach programs to increase awareness of Long COVID to the public and designated community partners
- Improving access to informed competent care for Long COVID patients with their family provider, avoiding early referral to specialty providers



The overall project aim of IMPACCT is to develop an educational and clinical infrastructure to improve awareness and understanding of Long COVID care by non-specialist clinicians and to expand access to Long COVID care using an evidence-based care implementation model.

“This AHRQ program offers resources to clinicians experienced with the care of Long COVID patients to effectively extend our effectiveness into the broader health community.”

— Karla Yoney, PA-C

“Seeing a provider who specialized in Long COVID was the turning point that allowed me to recover, return to work and avoid permanent disability at a young age.”

— Patient, UPMC Post-COVID Recovery Clinic





San Antonio Long COVID Care Network

San Antonio, Texas

MPIs: Monica Verduzco-Gutierrez, M.D.; Lisa Smith Kilpela, Ph.D.; Joel Tsevat, M.D., M.P.H., UT San Antonio

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[Rehabilitation services
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PROGRESS

- Aim 1: In first 17 months: 887 patients seen, 371 new patients and 1,115 encounters
- Aim 2: ECHO telementoring for rural primary care providers, community health workers and other healthcare professionals ongoing
- Aim 3: Held 17 focus groups among underserved adults (N=155; age 18-83 years; 77% female; 74% Hispanic; 73% less than college degree; 24% unstable housing)

INNOVATIONS

- PM&R-led Long COVID (LC) care model
- Multidisciplinary clinic embedded within an academic health system
- Engaged communities facing LC health challenges to bi-directionally inform resource pathways

COMMUNITY IMPACT

- AHRQ-funded initiative improving access, workforce capacity and systems-level LC care across South Texas
- Building trust in communities facing LC health challenges by engaging them in our efforts to improve LC care and resources

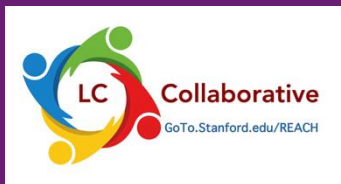


AIMS

- 1) to provide holistic, multidisciplinary care for LC at UT Health San Antonio
- 2) to collaborate with community partners on best practices for LC evaluation and management
- 3) to share up-to-date LC information with our South Texas community and the learning network

"I really like the ECHO sessions because [they] are designed to help primary care clinics."

— Dr. Oscar Garza, Family Medicine Clinic, Pearsall, Texas



Long COVID Care Resources and Education to Advance Community Health (REACH)

Stanford, California

MPIs: Linda Geng, M.D., Ph.D.; Hector Bonilla, M.D., Upinder Singh, M.D., Stanford University

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PROGRESS

The program has improved community awareness and education on Long COVID and strengthened support for primary care providers in safety-net clinics through peer-to-peer training and consultation. Initial findings from these efforts have been presented at national and regional conferences, with manuscripts submitted and in progress.

INNOVATIONS

- Long COVID resource website
- Multilingual patient education materials (pamphlets, flyers and self-care video series)
- CME-accredited clinician webinars
- Long COVID healthcare professional toolkit
- Referral pathways from FQHCs with priority fast-track
- Peer-to-peer clinician education and training

COMMUNITY IMPACT

- Codesign community outreach, engagement strategies and dissemination with FQHC partners
- Community Advisory Boards with input from patients, caregivers, clinicians and public health representatives



The REACH program aims to expand and improve care for individuals with Long COVID through academic-community partnerships, educational outreach and supporting primary care. Stanford's multi-disciplinary Long COVID program is collaborating with safety-net health systems San Mateo Medical Center and Community Health Center Network to expand care for patients with Long COVID.

"I intend to integrate updated assessment tools and management strategies for Long COVID into my clinical practice. This activity enhanced my appreciation for interprofessional collaboration, highlighting the importance of coordinated care among specialists to address the complex, multisystemic nature of Long COVID."

— Participant attendee at the May 2025 Stanford CME webinar: Unraveling Long COVID Care: Clinical Advances and Future Directions



UW Medicine Long COVID Clinic

Seattle, Washington

**PIs: Jessica Bender, M.D., M.P.H.; Janna Friedly, M.D., M.P.H.;
Nikki Gentile, M.D., Ph.D., University of Washington**



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PROGRESS

Spanning patient care, community partnerships and clinician training, this project has made meaningful progress in expanding the footprint of Long COVID care across the region.

INNOVATIONS

- Expanding primary care capacity through eConsultations, office hours and forthcoming asynchronous online course
- Group visit model spanning symptom self-management, cognitive rehabilitation and integrative medicine, expanding care capacity by meeting patient demand at scale
- MSW practicum preparing a workforce to support people with Long COVID through the social and structural realities of complex chronic illness

COMMUNITY IMPACT

By equipping more clinicians in their own communities, we can extend our reach far beyond what any single clinic could achieve alone. Our next step is to begin building an interstate network of trained clinicians to sustain and scale that community impact.



This project aims to improve access to multidisciplinary Long COVID care throughout the WWAMI region (Washington, Wyoming, Alaska, Montana, Idaho) through three intentionally connected aims: clinical care, community collaboration and clinician education, each designed around a common theme of expanding awareness and access.

"Wow, I felt really listened to and was surprised that there were recommendations that might actually help my patient to feel better."

"Thank you so much for your time, expertise and the resources shared. I am sharing this clinic with my colleagues in psychiatry and primary care."

— Feedback from PCPs who attended Long COVID Clinic office hours



UCSF Long COVID Care Network



San Francisco, California

PIs: Lekshmi Santhosh, Vivek Jain, Michael Peluso, Edwin Charlebois, University of California, San Francisco

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PROGRESS

- Established the ZSFG Long COVID Clinic (LCC) at SF General Hospital — one of first county/safety net hospitals to offer services
- Expanded Long COVID care at UCSF Health clinics
- Delivered educational presentations for clinicians and community-based organizations

INNOVATIONS

- Incorporated pharmacy services and developed low-dose naltrexone prescribing guidelines
- Incorporated mental and behavioral services into our safety net clinic

COMMUNITY IMPACT

- Outreach and recruitment of patients with Long COVID from partner community-based organizations



Two members of UCSF's physical and occupational therapy team presenting a poster on the UCSF Health Long COVID Clinic model (Long COVID International Conference, Boston, MA, November 2025).

"This is providing care for a new syndrome, but within an old system, and how to get existing resources and structures to work for a disease that we're still trying to understand. It's a very unique kind of enterprise."

— Vivek Jain, M.D., M.A.S., FIDSA, Professor of Medicine, UCSF





Keck USC COVID Recovery Clinic

Los Angeles, California

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PROGRESS

Ongoing multidisciplinary care at clinic with RN care coordinator. Started 8-week workshop program. Continuing support group and regional care providers group.

INNOVATIONS

Workshop groups with OT and PT incorporate use of Visible app with wearable heart rate monitor. Planned to expand to more participants.

COMMUNITY IMPACT

Half-day educational conference co-hosted with UCLA for Primary Care (targeted to FQHC providers).



- Care coordination expanded with RN coordinator and plan to add physician assistant
- Workshop groups started and available to patients with insurance barriers
- Community education: CME course provided, SoCal Long COVID Providers bimonthly meetings, educational video in progress

"The day I walked into Keck was the first time I was heard and understood. The staff — all of them — were so knowledgeable about Long COVID. I left the appointment in tears because for the first time since I got sick, I had hope. I still have Long COVID. Maybe I always will. But because of the staff at Keck, I am able to live my life."

— Elisabeth, Patient at Keck COVID Recovery Clinic