NATIONAL ASSOCIATION OF Community Health Centers®

"Prepare Not Panic: COVID-19 CDC Update and the Health Center Response" Webinar Transcript

Friday, March 6, 2020, 1-2 pm Eastern

Speakers:

- Ron Yee, MD, MBA, FAAFP, Chief Medical Officer, National Association of Community Health Centers
- Lisa M. Koonin, DrPH, MN, MPH, Senior Advisor, Centers for Disease Control and Prevention
- Tina T. Wright, Director of Emergency Management, Massachusetts League of Community Health Centers/Chair, Emergency Management Advisory Coalition (EMAC)
- Lisa DiFedele, MPH, Infection Prevention and Control Administrator, International Community Health Services
- George Lee, MD, Chief Medical Officer, Asian Health Services
- Marisol Murphy-Ballantyne, MSHCA, Director, Digital Communication, National Association of Community Health Centers

Ron Yee, MD, MBA, FAAFP:

On behalf of NACHC, our board of directors, staff, and CEO Tom Van Coverden, we thank you for joining this critically important webinar. Prepare, Not Panic for the COVID CDC update and health center response. First, I'd like to send our thoughts and prayers to those who've lost loved ones or are in critical condition due to the COVID-19, and for those who are on the front lines assessing and caring for the 29 million people we serve through the Community Health Center program. Just know we're with you. Health centers are the largest network of primary care providers in the nation with 12,000 sites in every state, territory, District of Columbia, and Puerto Rico and are strategic in any kind of emergency response, whether that be a natural disaster, fire, or communicable disease, we know how to do this. The bios will be available on the NACHC website, so I'll abbreviate introductions so that we can get to the all-important content our speakers have and the Q&A time.

Ron Yee, MD, MBA, FAAFP:

I'd like to introduce our speakers altogether in order of presentation. First we have Dr. Lisa Koonin, who is a senior advisor for the CDC and supporter of the CDC COVID-19 response team. In her prior 31 years and career at the CDC, she served as a leader in multiple national international emergency responses including hurricanes, the Marburg hemorrhagic fever outbreak in Africa, H1N1 influenza pandemic, the avian influenza outbreak in China, Ebola and Zika response and now Corona virus. Lisa will share information regarding the status, science and strategy for addressing COVID- 19. After Lisa, we'll have Tina Wright, who's the director of emergency management at the Massachusetts League the Community Health Centers, where she's served for almost 20 years. Tina is also the chair of the Emergency Management Advisory Coalition or EMAC addressing emergency management issues across the nation, especially for health centers and she'll share from her vast experience with emergency preparedness and response.

Ron Yee, MD, MBA, FAAFP:

Next, Lisa DiFedele is an infection prevention and control administrator at King County Health Department in the state of Washington. Lisa also works at International Community Health Services in Seattle, Washington. She has special insights as Washington state has seen at least 70 cases of coronavirus with multiple deaths up to this point. Lisa understands the need for a strong working

relationship between public health and primary care, specifically for Community Health Centers and the local health department. Dr. George Lee is a Family Physician and has worked with underserved Asian Pacific Islander populations in Alameda County, California for more than 25 years. He serves as the Chief Medical Officer for Asian Health Services in Oakland, California. Dr. Lee understands the frontline aspects of health and response and management dealing with the emerging issues like COVID-19 and will share the practical aspects of what they're doing on the front lines of care at Asian Health Services. Finally, Marisol Murphy Ballantyne is Director of Digital Communication at NACHC, will share about NACHC resources related to COVID-19. Dr. Koonin, I will let you lead us off.

Lisa M. Koonin, DrPH, MN, MPH:

Thank you so much. It's a real privilege to be here with all of you and your colleagues and thank you for your time. I'm going to just run through some overview comments first just to give everyone an update. Then talk about CDC is approach for the COVID response and then focus on some specific guidance that we published this week for healthcare facilities. Just want to make sure, Ron that you can hear me clearly.

Lisa M. Koonin, DrPH, MN, MPH:

Thank you very much. All right, so everyone is very aware of this expanding global outbreak of COVID-19 it is growing in a number of countries and including in parts of the United States and the potential public health threats posed by COVID-19 is high, both the globally and to the United States, but individual risk is dependent on exposure. Under the current circumstances certain people will have an increased risk of infection. For example, people living in communities where ongoing community spread is occurring, healthcare workers caring for patients with COVID-19, close contact of persons who are ill with COVID-19 and travelers returning from affected international locations where community spreads occurring at elevated levels.

Lisa M. Koonin, DrPH, MN, MPH:

There have been, as of today, 99 reported cases of COVID-19, 30 of these cases have occurred through person-to-person spread, 20 cases occurred in persons who had traveled to international areas with the same transmission, and 49 of these cases are still being investigated to determine the source of exposure. On March 4th, CDC updated his guidance for evaluating and reporting persons under investigation and in that updated guidance the criteria for evaluation of a person under investigation was expanded to a wider group of symptomatic patients. As of March 5th, CDC has issued the following travel notices, a level 3 notice which is the highest level to avoid nonessential travel to China, Iran, South Korea and Italy.

Lisa M. Koonin, DrPH, MN, MPH:

Level 2 travel notices which means practice enhanced precautions to Japan and particularly for older persons, and level 1 notice, practice usual precautions for Hong Kong. CDC also recommends that all travelers reconsider cruise ship voyages into or within Asia at this time and this is consistent with guidance by the US State Department. As you all know, the situation is rapidly evolving, every day CDC is constantly reviewing and updating its guidance as needed and updating the website. Since this outbreak was noticed and detected in China, CDC has been using a containment strategy, which means efforts to screen incoming travelers, limit of flights into the country to certain airports, and then track and follow the contacts of all those who may be infected and exposed.

Lisa M. Koonin, DrPH, MN, MPH:

We will be moving, just like to some States, we'll be moving from a containment strategy to a mitigation strategy very gradually as the need is pronounced and that mitigation strategy is to respond with a targeted layered approach. Given the evidence of increased community spread, we need to make sure that health care facilities are prepared and planning can help mitigate that impact of potential surge on the healthcare system. The most important principles for healthcare systems and clinics are to reduce morbidity and mortality, these are our goals, minimize disease, transmission, protect healthcare personnel and preserve essential health services. To minimize disease transmission, we have produced guidance that characterizes an important paradigm shift to reserve care for those who most need face-to-face care and implement strategies to shift care to home when it's appropriate, strengthen triage options that are not face-to-face and to be able to take infection control principles from the moment the patient walks in the door all throughout the time that they're in our facilities.

Lisa M. Koonin, DrPH, MN, MPH:

Let me go through a little bit of the guidance with you. I will give the link to the organizers of this webinars so that you can find these guidances and I encourage you to check the CDC website every day because new guidance is being issued. We've structured the guidance in two ways, actions to take now in communities that do not have widespread outbreaks, and then actions to take when there is a community outbreak. First of all, actions to take now in preparation for an outbreak for those communities that have not seen a large number of cases. The first recommendation is to designate time to meet with clinic staff, educate them on COVID-19 and start planning for how you will manage a large influx of patients where they will be received, how they will be routed through the facility with the aim to keep patients with suspected COVID-19 infection away from other patients.

Lisa M. Koonin, DrPH, MN, MPH:

Explore alternatives to face-to-face triage and visits. We are really strongly advising that practices reach their patients and advise them to call first before they come into the clinic to conduct assessment and triage through Telehealth, patient portals, advice lines, online self-assessment tools or telephonically. To also make sure that there are staff that are identified to be able to conduct those telephonic and Telehealth interactions so that patients don't have to wait long to speak to someone. Determine algorithms to identify which patients can be managed by telephone and advised to stay home with guidance and instructions and perhaps monitoring and which patients need to be sent to emergency care, which patients need to come into your facility. Also to instruct patients that if they have respiratory symptoms, they should call the facility before they leave home so that the proper staff with proper PPE can greet them.

Lisa M. Koonin, DrPH, MN, MPH:

It's also important to be able to be ready when COVID is spreading in the community and the first recommendation is to work with local and state public health departments to understand the impact of spread of the outbreak in the community and to be informed about their guidance. To make sure that you have designated staff who will be responsible for caring for these patients and will not be caring for non-COVID patients. A plan to monitor health care workers and ensure maintenance of essential functions to make sure that staff are aware of sick leave policies and are encouraged to stay home if they are ill with respiratory symptoms. Then when possible consider managing mildly ill patients at home, assessing the patient's ability to be managed at home to make sure that the caregivers of those sick persons have clear instructions for what to do and the warning signs for when they need to seek

care or call back to the clinic and if possible, identify staff who can monitor those patients with daily or frequent check ins.

Lisa M. Koonin, DrPH, MN, MPH:

Finally, there are specific guidances for outpatient facilities to reduce the amount of surge on the facility including rescheduling non-urgent outpatient. Consider reaching out to the panel of patients who may be at higher risk for COVID-19 and early data suggests that older people are twice as likely to have serious COVID-19 illness. Make sure that people have their medication refilled, sufficient medication refills and instructions on what to do if they become ill and then think about eliminating any kind of patient penalties for cancellations or missed appointments. We are eagerly awaiting more information about the clinical course of this disease. We know we've read plenty of case reports and we have data from cases in other countries, but we are keen to learn what we can about the cases in the US and in doing that we'll adjust our guidance accordingly. I'll be happy to take questions at the end of the session. Thank you.

Ron Yee, MD, MBA, FAAFP:

We appreciate you synthesizing all of this information the CDC has and I've been on the webpage and there is a lot there but thank you for pulling out the salient points and practical recommendations. Next, we'll move to a Tina Wright to speak with us about emergency management, Tina.

Tina T. Wright:

Hi Ron. Thanks everybody for having me today. I'm proud to be here to represent Primary Care Associations and as most of you hopefully know, Primary Care Associations really do exist today to support our health centers and we're all each uniquely staffed and resource to do so. Therefore, our roles are going to vary from state to state in emergency management. Some Primary Care Associations have very robust staffing and programs, some operate in partnership with State Departments of Health and healthcare coalitions for emergency preparedness and response. Some do really great training and education and it's important for each health center to be aware of the role of your Primary Care Association, not only in this situation but other emergencies as well. All PCAs do however, play a role in being a conduit of information for what is impacting our health center members but also with impacting your patients.

Tina T. Wright:

Therefore, it's really vital for Community Health Centers to report operational impacts for this emergency and any other emergency to your PCA. Knowing your impact really helps us to be able to help you. We can come together with HRSA to help troubleshoot and [inaudible 00:14:24] as well. We have also been able to come together as Primary Care Associations, as a community of professionals that do emergency management work for community health centers through our Emergency Management Advisory Coalition, what we call EMAC, PCA EMAC. We've been coming together monthly for over a decade, we're able to share best practices, tools and templates. We have an online workspace that we also come together on which has been really a wonderful collaboration. We have tools, templates, we connect each other to subject matter expertise and much, much more. So if your health center has a need, whether it's about a policy for staffing, when shortages happen, whether it's about infection control, we can find those resources, if your PCA doesn't have it readily available, that PCA can actually come to EMAC and ask the question of all 49 of our members.

Tina T. Wright:

We're also expanding all the time to include others as well. We work with the other national cooperative agreement organizations like NACHC, like all the other 20 NCAs, now called NTTAP, National Training and Technical Assistance Partners... I'm going to get the acronym wrong. Partners, Training and Technical Assistance Partners. We also come together to support each other, PCA to PCA in a time of crisis and we have robust relationships with relief partners such as direct release and AmeriCares and really have the network into some of the other federal agencies. So we've been really fortunate to grow this PCA EMAC over the years and really to see what each other are doing. My co-chair of PCA EMAC, Alex Lipovtsev, from CHCANY, the Community Health Center Association of New York, has actively been collecting and updating our email, excuse me, our website, www.pcaemac.org to really post what each other, other PCA's are posting to have information about coronavirus readily available for their health centers.

Tina T. Wright:

You can easily catch a glimpse of that by going to www.pcaemac.org and clicking on the COVID-9 icon to see all the great work that PCAs are doing and finding that information, having it readily available just a click away. HRSA has also activated Primary Care Associations that have confirmed coronavirus positive patients. What this means is they are going to be asking Primary Care Associations to collect data and operational impact from our member health centers. I would just ask, there's over a thousand people on this call today, I would just ask you to definitely please have patience with us with our data requests, this is a new method of collecting for us at the Primary Care Associations. We're sending out lots of notifications and we know that there's such a thing of notification fatigue and alarm fatigue, so we ask you please to have patience with us, let us know what is working well, what doesn't work.

Tina T. Wright:

We are here to support you and want to ensure you that we're doing so in a very meaningful way for you, our members, our health centers and in collaboration with our partners at NACHC and other organizations. We definitely recommend that you have more health centers review your emergency operations plans and your business continuity plans. Specifically around policies around staffing, what to do if you are short-staffed, follow the public health and CDC guidelines and best practices on optimizing your personal protective equipment for your staff, making sure your staff feel safe in caring for patients. I'm happy to answer any questions at the end of today's call as well. So I would want to thank you and turn it back over to Ron.

Ron Yee, MD, MBA, FAAFP:

Thanks Tina. Very practical suggestions again and thank you for what you were doing with that larger PCA group to help the health centers overall. So we'll continue on. Let's move on to one of the public health side and locally. We're going to have Lisa DiFidele come and speak with us about what's going on in King County, near Seattle, Washington in that area. Lisa.

Lisa DiFedele, MPH:

Thank you so much. So yeah, my name is Lisa DiFedele and I am the infection prevention and control administrator for International Community Health Services, ICHS. ICHS is a community health center, which was founded in 1973, we started out as a storefront clinic in Seattle, Washington's International District serving elderly immigrant populations. We operate 11 locations including four medical dental clinics, a mobile dental clinic, a vision clinic, a senior care facility, and two school-based health centers.

In 2019, we served over 32,000 people. Three out of four of our patients are low income and more than half of ICHS patients are limited English proficient. We provide interpretation services in over 50 different languages.

Lisa DiFedele, MPH:

Our top language needs are Cantonese, Mandarin, and Vietnamese. 7% of our patients are uninsured due to income and residency restrictions and 52% qualify for Medicaid. As of today at 9:00 AM there's been 70 cases of COVID-19 and 10 deaths due to COVID-19 in Washington state. With reported community spread of COVID-19 in Seattle, we've raised the level of concern about the immediate threat for us at ICHS and we're taking the situation very seriously. While most people in the United States will have little immediate risk of exposure to this virus, and 80% of those who contract it will only have mild symptoms. It's still a great concern for those of us who provide safety net care. Here at ICHS, we're staying abreast of the rapidly evolving situation, and we are nimble to respond quickly to changing recommendations and knowledge. So we've been working hard since the beginning of this outbreak to ensure our patients, staff, and community are taking the appropriate measures to curtail the spread of COVID-19.

Lisa DiFedele, MPH:

Our focus has really been on calm preparation in two different arenas. We've worked on preparing our clinic, and supporting both our patient community and our broader community in Seattle. Our clinic preparation has focused on logistical readiness for isolation, identification and escalation of potential COVID-19 cases. Our community preparation has included allaying fears and working to prevent stigma and discrimination.

Lisa DiFedele, MPH:

Our clinic efforts have included dissemination of accurate information to staff. A risk assessment of our patient population. Production of novel screening processes and novel workflows. Implementation of a strict policy for staff returning from travel. Ensuring that proper training and resources for personal protective equipment and cleaning of the clinic are available. Ensuring that proper disinfection is occurring at all of our sites. And education, training and just so much communication, communication, communication to our staff. We also have activated the Incident Command System.

Lisa DiFedele, MPH:

So when Washington announced the first case of COVID-19 in the state on January 17th, one of the first tasks we took on was to create a novel workflow, which included screening questions to be used by both our front-desk staff and our call-center staff. The screening, which is done on first contact with our patient either by call or face-to-face, includes questions about travel and symptoms and it's intended to very early on, identify suspect COVID patients.

Lisa DiFedele, MPH:

This workflow has been updated six different times to align with the CDC guidelines and quarantine orders from the federal government. Training of our front-desk staff and call center has been an evolving task, which has included many levels of leadership. Following identification of a suspect COVID case, our workflow provides guidance on isolation of that patient, and then guidance to our clinicians on how to evaluate a person under investigation using the CDC guidelines.

Lisa DiFedele, MPH:

At this point, ICHS is not able to collect specimens or transport them to our state lab for testing, so our workflow exemplifies how to do a warm handoff to one of our area ED's for specimen collection. One important step is ensuring we triage the patient in consultation with our local public health, so following identification of a suspect COVID patient.

Lisa DiFedele, MPH:

Our providers are working with myself and King County Public Health, to determine if testing is warranted. In the situations where testing is warranted, a warm handoff is going to occur where we work with the patient to ensure that their travel to the ED is safe and they're not exposing anyone else.

Lisa DiFedele, MPH:

We've accomplished dissemination of accurate information through multiple avenues. Early on in the outbreak, I was holding weekly meetings for all leadership and management and their designees. These meetings included an assessment of the epidemiology and the spread of the disease throughout the world. Newly emerging research on COVID, and our local response at ICHS, including the roll-out of the novel workflow and the staff restrictions that I spoke of.

Lisa DiFedele, MPH:

The information for these meetings was compiled from our partner organizations, including the WHO Daily Situation Reports, the CDC, the State of Washington, Department Of Health Literary Reviews and King County Public Health Resources. And then once our Incident Command System was activated, our communication strategy shifted from me being the primary point of contact, to relying on all leadership to provide information to our staff. And this step has really been imperative, as the concern and questions about COVID have ballooned, as more cases are seen in Seattle and beyond.

Lisa DiFedele, MPH:

We have made it a priority to keep our staff informed. Ideally we want them to stay calm and be able to answer all questions posed to them and a knowledgeable and factual way. As I mentioned, we have activated the Incident Command System, which is part of our emergency response policy. Incident Command System or ICS, is a standard emergency management system specifically designed to allow us to respond in an integrated and organized way, to the complexity and demands of single or multiple incidents of large and small emergencies.

Lisa DiFedele, MPH:

Stepping up ICS at ICHS has been very important in the organization and management of this very complex and rapidly changing situation. We've also spent a lot of time looking at and training staff on personal protective equipment. We've had many conversations about the need to use droplet precautions to include a face mask and eye protection for each and every patient that presents with respiratory illness. We've been doing auditing at all of our sites and with staff to ensure that they're using PPE properly and when appropriate.

Lisa DiFedele, MPH:

Prior to COVID, we had decided to start using PAPR (Powered Air Purifying Respirator) in our clinics, so part of my job in the last few weeks has been to create a training program and ensure that our providers are knowledgeable in PAPR usage. We also have had Just-In-Time and 95 Fit Testing for many of our clinicians.

Lisa DiFedele, MPH:

Other than our clinic preparations, we've also been working in our community and with our community partners, and this has included regular meetings with community partners to discuss COVID in the community. And our CEO also was instrumental in both organizing and presenting at a King County organized press conference, which focused on urging everyone to counter bias and harassment. And with that in mind, we have actually started an anti-stigma campaign out of King County.

Lisa DiFedele, MPH:

ICHS and community partners anti-stigma campaign has included the following messages. "Coronavirus does not recognize race, nationality, or ethnicity. Having Chinese ancestry or any ancestry does not make a person more vulnerable to this illness. Wearing a mask does not mean that a person is ill. People wear masks for a variety of reasons, including to avoid pollen and air pollution, and for cultural and social reasons. We should not judge someone for wearing a mask or assume they are sick.

Lisa DiFedele, MPH:

You can interrupt stigma. Start by sharing accurate information, avoid spreading misinformation, stay informed through reputable and trusted sources. Speak up if you see, hear or read misinformation or harassment. Gently correct the false information and remind the speaker, 'prejudice, language and actions make us all less safe.' And show compassion and support for those who are most closely impacted by COVID.

Lisa DiFedele, MPH:

In addition to stigma, the weakening of the ACA combined with the federal anti-immigrant actions have created real and perceived barriers to care. Real because of cost increases in additional criteria for coverage, perceived due to fear and intimidation to use services that are rightfully available to Medicaid, uninsured and underinsured cases. This effect can be seen in programs like Women, Infant And Children's Program, which is not impacted by the recent federal change in the definition of public charge. Both these real and perceived barriers can prevent patients from seeking care when they are ill, which makes the job of stopping COVID-19 even harder.

Lisa DiFedele, MPH:

I thank you all for listening to my experience and the preparations that ICHS has taken to protect our patients, staff and community from COVID-19. We're calmly prepared to continue to be a health center welcoming and treating our diverse population of patients with compassion and expertise. ICHS is ready to handle COVID. ICHS has experience and expertise in handling epidemics, so our patients can be assured of appropriate care and protection as well as safety.

Lisa DiFedele, MPH:

As more COVID-19 cases continue to be identified in the US and in King County, our number one priority remains the health and well-being of our local communities. We know that the unknown can be scary, but we urge people to stay calm. In the meantime, don't panic, and to protect everyone please wash your hands. Don't touch your face. Cover your cough and cold. Exercise social distancing. Stay home if you are ill. Clean your handheld devices and call your doctor if you're experiencing any symptoms. Thank you for listening.

Ron Yee, MD, MBA, FAAFP:

Thank you Lisa and thank you ICHS for all you were doing for the patients, especially in King County there. So we will continue to drill down to the frontline aspects of patient care and what that looks like. So thank you for kicking that off Lisa, and we'll continue to move on to Dr. George Lee at Asian Health Services in Oakland, California. Dr. Lee.

George Lee, MD:

Great. Thank you Ron. So I'm George. I'm the Chief Medical Officer at Asian Health Services. And we are a community health center that was founded in 1974. We have 30,000 patients and we serve them in 14 different languages. We are located in the San Francisco Bay Area but headquartered in Oakland.

George Lee, MD:

So our objective really, is to share our experiences in responding to COVID-19 and also share our best practices and challenges. I do have a slide show and I think it will be posted after the call ends.

George Lee, MD:

So to just give an overview of our response, in January we convened an organizational Incident Response Team. We designed and implemented our response. We especially focused in on screening procedures, supply chain control, and also PPE training.

George Lee, MD:

In February, we held a community meeting with our county supervisor, our business leaders, County Public Health Department and media to disseminate information to the community. We also started pushing out reminder calls addressing COVID-19, and we started having a series of trainings both to our staff in the larger components, and also to interdepartmental trainings as well and also trainings to the board. In March now, we are starting to turn towards community mitigation and we're also starting to work on telehealth visits.

George Lee, MD:

So in terms of sharing best practices, our Incident Response Team really had to pull across the entire organization. We set up the Incident Commander, as well as Logistics and Public Information Officer. We really required active participation from HR and facilities, and we also really have to think about how to manage our medical as well as our nonmedical sites. For instance, dental and mental health sites and also our sites that did not have any airborne isolation rooms such as our school-based sites.

George Lee, MD:

So we had very clear protocols that were separated by particular job function. They were very detailed and they actually get printed out with every patient that is deemed necessary for isolation. So for instance, it'll even include things like if you're an NP or a PA, you should notify the preceptor before heading into the room. You should don your PPE, follow your posted instructions. If translation is needed, use the telephone. Have the interpreter staff call the room extension. If you need to collect specimens, call out to the nursing station after visit is done. Patient can be sent directly home, no need for checkout.

George Lee, MD:

So it's that level of detail that we provide and it's all printed on a piece of paper, actually two pieces of paper that includes things like the public health number, protocols for home isolation, nebulizer treatments, PUI (Person Under Investigation) definition, exactly how to do specimen collection and also QI tracking.

George Lee, MD:

So in designing these protocols and in looking at communications, we really realized that we needed to digest and simplify things for staff. So for instance, even though the PUI definition calls for history of travel within 14 days of symptom onset, we couldn't really imagine how this would play out practically at the front desk. Because if a patient comes in and says, "Oh, I had a cough on Monday, and then I traveled on another date." Then the front desk staff would have to start thinking and calculating 14 days from symptom onset, which seemed to be a very long interaction at the front desk. So we simply made our screening protocol to be travel within the past three weeks.

George Lee, MD:

We also tried to simplify the definition of post contacts to just someone that you live or work with, and that was something that was easy for the front desk staff to implement. We also had targeted weekly communication to specific groups such as managers and also direct care staff like the providers and nurses, and we also had messaging directly to all staff.

George Lee, MD:

We have signages, signs that were posted in the sites, as well as pushing outpatient reminder calls. And the context of the patient reminder calls and the script was something like, "If you or someone you live with have returned from international travel in the last 14 days, we recommend the following, monitor yourself for fever and cough. If you have a non-urgent appointment, please consider rescheduling. If you have any symptoms, please call ahead before coming to your appointment."

George Lee, MD:

And education-wise, we rolled out videos for people to watch about how to use PPE. We also did in-person training in smaller groups by department. And we also allow people to practice their skills because donning and doffing PPE is really something that is a motor skill that needs to be a practiced.

George Lee, MD:

We also posted PPE instructions on the negative pressure rooms. For instance, we posted how to don PPE on the front door of the negative pressure room, and then we posted instructions on removing PPE

on the backside of the door so that people can see it on their way out. So it's really about making the right thing to do the easiest thing to do.

George Lee, MD:

In terms of equipment, we pre-package PPE so that they were easy to use. We also obtain stethoscopes for use in isolation rooms, and we also created a central management system with specific targets and analysis. So for instance, I have a spreadsheet that will tell me exactly how much inventory we have of gowns, gloves, masks in N95s, et cetera. And we've created targets for each of those things and purchasing those that whenever we get down to 80% of our target, they will go ahead and order new PPE supplies. We also have analysis about our run rates of the different PPE equipment that we have, and we've been sourcing multiple vendors to try to get enough PPE.

George Lee, MD:

For facilities, we've increased this instruction of waiting rooms and also high touch areas, and we've confirmed airborne infection, isolation room functionality. We've also done surge planning to decide and identify other rooms that can be used if there's no negative pressure rooms available and we also purchased portable HEPA filter units.

George Lee, MD:

In terms of our work with the community, we've had that community event that I mentioned earlier with our partners and media. We've also pushed out messages through WeChat, as well as radio and newspaper messages, as well as a patient newsletter. One thing I did want to point out is our quality improvement projects as well. Even related to COVID-19 we track all cases of possible COVID-19 through a chief complaint of isolation, and we pull a report based on that particular keyword of isolation. And we do a weekly review to ensure that good clinical care and follow-up has been accomplished.

George Lee, MD:

We also have a pretty collaborative environment. So we gather questions and answers and push out an FAQ as well, and we try to refine protocols and support staff as we answer their questions. So for instance, the stethoscopes that we use for isolation room, that was gathered through a process of working with our staff and answering their questions.

George Lee, MD:

We've tried different pilots. Some of them have worked and some of them maybe have not worked. We tried screening at the front door but the percentage was too low to make it worthwhile, and currently we are going to start piloting Telehealth as well.

George Lee, MD:

For HR, we've worked on return-to-work policies in terms of returning from travel or returning from sick leave, plans for telecommuting as well as protecting high risk groups. For our Emergency Operations Plan, we've talked about community mitigation planning, especially in regards to home visits that we do, especially in the specialty mental health department and also outreach events and conferences and meetings. We've set up emergency text groups and we've also talked about critical functions and backups, and not just the people like the CEO or the CMO, but a very important people like purchasing, et cetera, that are critical to our functioning.

George Lee, MD:

Different challenges that we face. We've had a lot of social media rumors. Trying to manage staff and patient anxiety. Trying to deal with the lack of PPE supplies and also some of the testing issues that have been confronting the nation, and also looking at the financial impact with a decrease in visits that we've been experiencing.

George Lee, MD:

So overall it's really about a coordinated response across the entire agency, and having clear, practical and targeted communications and ongoing work with community and partners. And Asian Health Services has a fabulous team that has done all of those things very well. Thank you very much.

Ron Yee, MD, MBA, FAAFP:

Dr. Lee, I really appreciate the specifics and the application of the CDC guidelines that you can have some gray areas in certain applications. And so I appreciate you sharing those details and I think, I loved what you said about, "Making the right thing to do the easiest thing to do." And sometimes we get caught up in things and we don't take a step back and be very practical.

Ron Yee, MD, MBA, FAAFP:

Thank you also for the broad approach including HR and purchasing, things that we don't think about often. So really appreciate that and thank you all for your presentations. We're going to spend some time now in Q&A and I'm going to turn over to Marisol Ballantine here at NACHC and she's been assessing the chat room with our staff and we'll have some questions and we'll direct them to the proper people. Marisol.

Marisol Murphy-Ballantyne, MSHCA:

Good afternoon everybody. I just wanted to first start off by saying that we are recording all of the questions that we are receiving and that we plan on answering them in an FAQ that will be available on the website early next week. So we hear you and we're trying to get to all these questions. Our first question is actually for you, Dr. Yee.

Marisol Murphy-Ballantyne, MSHCA:

Does NACHC anticipate that disaster relief funding may be available to adversely affected health centers?

Ron Yee, MD, MBA, FAAFP:

Sure. I think if you've been following the news of that $8.3 billion that was approved by Congress, the president signed it this morning. There's $100 million that will go to community health centers specifically. So the bureau and others have contacted us and we're actually getting to give input on the use of those. So we know that PPE and other things are very important.

Ron Yee, MD, MBA, FAAFP:

We've also had discussions about surge staffing. We've talked about labs that may not be covered. Pharmaceuticals for, we don't have an antiviral yet, but for supportive care, for cough and cold and fever. So those are in some of the things that are in the discussion.

Ron Yee, MD, MBA, FAAFP:

So I don't know specifically the conclusion that they've come to yet that we, NACHC, has been able to give some input on that. So there is $100 million and we're pushing for more. We know that's a very small amount compared to the $8.3 billion, but we're working to have additional work go towards that and additional funding.

Marisol Murphy-Ballantyne, MSHCA:

Great. So, and I just want to remind everybody that if you have a question, please make sure to type it into the chat.

Marisol Murphy-Ballantyne, MSHCA:

So Dr. Lee, I have a question for you. Can you provide any advice on the practical use of PPE in an ambulatory setting, particularly among health centers that do not have the resources to implement airborne precautions or the supplies they need including masks and gowns?

George Lee, MD:

Yeah. So on the CDC guidelines there are actually instructions about what to do in terms of extending the use of N95. And also one of the very good pieces of information is about infection control for our healthcare providers as well. It will list out specifically what PPE items you should be using and the risk of exposure based upon different situations. If you look at that, actually the key situation is to control the source patient and that will actually determine the level of risks for the health care provider. So you have to just make sure the source patient is controlled with a mask and then the rest of that is really looking at droplet precautions and contact precautions. Those are the main issues.

Marisol Murphy-Ballantyne, MSHCA:

Thank you. So Dr. Koonin, do you have anything to add to what Dr. Lee just said?

Lisa M. Koonin, DrPH, MN, MPH:

Well, thank you. Well said. And our staff is currently looking at all of this guidance regarding PPE in light of all of the issues that we're hearing about in terms of surge and supply chain disruptions. Please keep checking our infection control guidance daily because if there are any changes or new recommendations, it will be posted on our website. Thank you.

Marisol Murphy-Ballantyne, MSHCA:

Fantastic. So I do also have another follow up for that, and Dr. Koonin, if you could help us with this one as well. How do we amend this advice for patients who are homeless and have no home?

Lisa M. Koonin, DrPH, MN, MPH:

This is tricky and very difficult because those patients are often in shelters or in other places. They can often move around quite frequently. And they also seek care in emergency rooms. So it's really working with social services, discharge planners in hospitals, homeless shelters and other locations, soup kitchens, where people come to try to see if there are services that can be provided, information that can be provided, education that can be provided to these folks. I know that public health and the safety net clinics work with this population and I'm sure folks in the local areas are very experienced in dealing with this.

Marisol Murphy-Ballantyne, MSHCA:

Thank you. And Lisa DiFedele, can we get your perspective on that question as well?

Lisa DiFedele, MPH:

Sorry, would you mind repeating the question?

Marisol Murphy-Ballantyne, MSHCA:

Sure. How do we amend this advice for patients who are homeless and have no home?

Lisa DiFedele, MPH:

Oh yes. That's a really, really tricky one. I think safety net care, we obviously want to be prepared to work and open our doors to that population. I know that there are some resources out there. I think that actually the CDC was putting on a webinar today on COVID in the homeless populations and that's certainly something that I think we all should probably review after we get off of this call as well. But I don't have any really good answers. It's a tough population to catch and it's a tough population to care for and ensure that their needs are met.

Marisol Murphy-Ballantyne, MSHCA:

Okay. Thank you. And Dr. Koonin, I have another question for you. Can you tell us a little bit about the clear use of masks and N95 versus surgical, do you have any advice on those since they are both in short supply?

Lisa M. Koonin, DrPH, MN, MPH:

[inaudible 00:44:24] as well. My colleagues from CDC have joined. We are doing some teleworking today and I don't know if my colleagues who are working in infection control were able to join. Ron, I don't know if they're available to answer that question, but if not, I will. I'm getting a message now. Let me see if Ryan Sagan has entered the call. And if so, if you could open his line, please.

Marisol Murphy-Ballantyne, MSHCA:

Let me check on that. I'm not sure if we have the capability to do that. Hold on one sec.

Lisa M. Koonin, DrPH, MN, MPH:

Well, I don't want to take too much time. But any of the questions on infection control, I'd prefer to have my colleagues answer since they are working directly with that.

Marisol Murphy-Ballantyne, MSHCA:

Great. So what we'll do then is we'll follow up offline and make sure to include that in the FAQs. Thank you.

Lisa M. Koonin, DrPH, MN, MPH:

Sounds good.

Marisol Murphy-Ballantyne, MSHCA:

Okay. So let's see. One more question. What are the best resources for information toolkits for community and social media resources for guidelines for training staff to address COVID-19? Dr. Koonin, I'm not sure. I'm pretty sure the CDC does have something regarding that communication and staff and communicating with the community. Do you know if there's a resource on the website?

Lisa M. Koonin, DrPH, MN, MPH:

Many resources, downloadable resources, one-pagers. And this is growing every day. We're trying to do everything we can to provide resources so folks can download and print those.

Marisol Murphy-Ballantyne, MSHCA:

Great. And Tina, do you have any follow up to that?

Tina T. Wright:

Just I was posting in the chat that the CDC does have a great digital toolkit on their website that is available for download with all the right talking points that we want to be putting out there about hand-washing as well as infection control and in different languages as well.

Marisol Murphy-Ballantyne, MSHCA:

Fantastic. And we are still getting some questions here. And all of those resources, we're trying to make sure we're uploading them also to the NACHC website, at least including the links so that they're easy to find. Okay.

Tina T. Wright:

Marisol, just as a follow-up to a previous question, I did share a link in the chat to a resource that one of our healthcare for the homeless programs here in Massachusetts provided that they use to help guide their infection control and isolation and quarantine for patients experiencing homelessness.

Marisol Murphy-Ballantyne, MSHCA:

Fantastic. Thank you so much. And we'll make sure to link to that as well. So Dr. Koonin, can you comment on exam room cleaning, HEPA filters? How do we best keep exam rooms clean or clean them afterwards?

Lisa M. Koonin, DrPH, MN, MPH:

We do have very specific environmental cleaning guidance on our website for healthcare facilities. Let me make sure to send that link to you so you can post it in the after call information.

Marisol Murphy-Ballantyne, MSHCA:

Okay, great. I was asked to repeat how much government funding is going to help health centers. As of right now, we ... Hold on one second. The recent bill that was signed by the president includes $100 million for health centers specifically. It is unclear at the moment how that will be distributed. So definitely we'll keep you posted not only on our website but through social media when we get more information on that.

Marisol Murphy-Ballantyne, MSHCA:

And so either Dr. Lee or Lisa DiFedele, if you could follow up on maybe what you do within your health center to keep the exam rooms clean and how to clean them afterwards, that would be fantastic.

George Lee, MD:

Sure. Actually for us, in terms of disinfecting a room after use, what you are supposed to do is wait an hour after they leave the airborne isolation room or whatever the length of time is if you know the air change rates for that particular negative pressure room. You want to have 99.9% removal prior to you entering the room. If you don't know your air change rates, then an hour should be good enough. And then after that, whoever's cleaning the room needs to be wearing contact precautions. So gloves and gown as long as they are using wipes. If they are using any kind of disinfectant that requires spray or there might be a potential splash, then they will also need to have mask and a face shield.

George Lee, MD:

And then I just wanted to add a little bit to some of the questions, answer some of the questions that were stated earlier. For the N95s, generally the recommendation is to do extended use if you were to try to extend their life as opposed to reusing. So basically keeping one on as opposed to donning and doffing them all the time. The other thing is that the FDA has made some other masks available through an EUA, an emergency use authorization. So some of the industrial ones are probably okay, like the R99 and the P100. So there are potentially other sources of masks that are available and I think those are posted on the FDA website as well.

Lisa DiFedele, MPH:

This is Lisa DiFedele. We are following exactly what was just explained in the cleaning. You do need to wait an hour. It took us a little bit of time to examine our air exchange rates and during that time we were using an hour. And then after examining them we discovered that an hour was adequate with our air exchange rates. We do not use aerosolized disinfectants because of staff allergies and concern for that. So we are using wipes and exactly how it was explained. And we make sure that those rooms are cleaned between each and every patient. We've stepped that up and we're auditing that now as well since it is so important because we don't know necessarily what individuals are coming in with COVID now that we're seeing community spread.

Ron Yee, MD, MBA, FAAFP:

So this is Ron Yee. And yeah, I wanted to add, if you do go to the website, the CDC website, they have some great documents about how you handle N95 volumes when you're starting to decrease the number you have. They have three different approaches. They've got the conventional capacity strategies where you might have adequate, but you feel like you're getting pushed a little bit. You're seeing those volumes go down. They have the next step is contingency. So when you start getting pushed and you're not having enough N95s. And then the third step is crisis alternative strategies. And that's all the way down to if you have no masks, finding people that have either survived COVID-19 or are younger people that are not at high risk, or healthy. So it goes all the way to that level. So I think if you want to prepare fully, I would go to the CDC website and look at the N95 strategies and they walk you all the way through that.

Marisol Murphy-Ballantyne, MSHCA:

Okay. So I have one more question and this one's for Tina I think. Our community has not seen COVID-19 yet, but the community is requesting that one clinic be the hub for all patients that need or present with COVID-19 symptoms for testing. Do you feel that this is something that should be done additionally there? Do you have any thoughts on combining sites in general?

Tina T. Wright:

It's an interesting theory. I have heard, for example in Rhode Island they have done that. Rather than sending people to their primary care provider where there could be other immunocompromised patients in waiting rooms, it's really hard sometimes in our health center environment to have isolation capacity that is adequate. And similarly with hospitals, there's this fear of people walking in and being able to infect others. So there has been movement in Rhode Island, for example, to send people to a designated testing site that does not see anyone else. They have set those stations up in Rhode Island. So that's one way of trying to contain the illness, especially for the more at risk populations.

Tina T. Wright:

There's no real best practice around this. It's just different strategies that can be used. And it really is at the discretion of the public health department of the state and what their infection control plans are for a disease outbreak. So we've seen many models mentioned for that. That is also the method that they're using for containment and treatment for Ebola patients. There are designated facilities for anybody who is going to be tested or treated for Ebola. So I can see why some States might be leaning towards that.

Ron Yee, MD, MBA, FAAFP:

Yeah, Tina, thank you. I think it's important to work with your local public health department if you're thinking about strategies like that and to really be in close contact to make sure everyone knows what's going on and you agree using the CDC guidelines.

Ron Yee, MD, MBA, FAAFP:

So thank you all for the questions that you all sent in. Anyone's we were not able to get to, we will put in our FAQs on our website. And now we want to spend a couple of minutes for Marisol to let us know what kind of resources are available through NACHC. And I'll finish this up.

Marisol Murphy-Ballantyne, MSHCA:

Great. So I just want to emphasize first and foremost that CDC is obviously the go to source for all information related to coronavirus. However, what we've done is we've created this page on our website that you can access from the homepage at NACHC.org. That is continuously updated with information and resources that are helpful and in some cases tailored to community health centers. And that page is located at www.nachc.org/coronavirus. And again it's really easy to access it from the homepage as well.

Marisol Murphy-Ballantyne, MSHCA:

And on that page you'll find emergency management resources, resources for providers, community resources, family [inaudible 00:55:20] public health reminders as well as resources for addressing

stigma. More importantly too is you'll find this transcript and recording of this webinar there early next week. The transcripts will be available in Spanish and English.

Marisol Murphy-Ballantyne, MSHCA:

If you have information, obviously we want to hear from you out there. You're on the ground so we need to hear from you. If you have any information or resources that are relevant to community health centers such as best practices, please feel free to share them with us by emailing preparedness@nachc.org. Please also follow us on Twitter at NACHC to stay up to date with the latest. Obviously this information is continuing to change and so we're trying to keep up just like everybody else and that is a really great place for staying up to date with what NACHC has as far as resources, information.

Marisol Murphy-Ballantyne, MSHCA:

Also something exciting. I wanted to let everybody know that if you tune in to C-SPAN on Monday morning from 9:00 to 9:30 ET, Dr. Yee will be speaking with host John McCartle about the role of community health centers as frontline responders to the novel coronavirus. So I hope you can watch that or maybe follow up with a link later on during the day.

Ron Yee, MD, MBA, FAAFP:

Thanks Marisol. And I want to thank everyone for joining us today. I think you've seen through the examples and discussion how health centers are really the implementation experts. We're able to take CDC guidelines and others and really get down to the front lines of what does this look like. And I appreciate it, especially the health centers and Tina from EMAC, to really share what this looks like on the front lines. That's where people need help. I think if we can continue educating our staff in our communities to this level, we can really quell a lot of that fear. So I think we've reached our objective, what we wanted for this call. We had the expertise of the CDC on the line and on the way down to whether it be state-based PCAs and down to the health center level of what does this look like.

Ron Yee, MD, MBA, FAAFP:

I want to say a special thank you to our speakers, attendees and the NACHC staff for orchestrating this webinar. Took a lot to get this together so quickly. As Marisol mentioned, the recording and transcription of the webinar and other resources will be posted on NACHC's homepage early next week.

Ron Yee, MD, MBA, FAAFP:

I did get an email I want to mention. I just heard this morning that I think LabCorp announced yesterday at 6:00 PM they were going to start providing the test for coronavirus in individual ambulatory care settings, such as doctor's offices and CHCs. So I think we still need to work through the billing, the transport of the specimens and all the things related to that. But I think that's something coming, which will be a game changer for us so that we can identify, isolate, and contain these cases. So I wanted to encourage you with that.

Ron Yee, MD, MBA, FAAFP:

So again, thank you all for joining us. I believe we met our objective, as I mentioned, to better prepare our participants today so that we can decrease panic for our staff, patients, and communities we serve and respond appropriately to the COVID-19 epidemic. So please stay healthy and on the front lines. And thank you again speakers and for everyone for joining us. Take care.