

**Leading in the Crisis: Flattening the COVID-19 Curve:  
*Managing Financial Insecurity During a Crisis***

Thursday, April 16, 2020  
1-2PM ET

**Speakers:**

- Dean Germano, MHSc, CEO Shasta Community Health Center
- Lathran Johnson Woodard, CEO of the South Carolina Primary Care Association and NACHC Board Chair
- Lisa M. Koonin, PhD, MN, MPH, Senior Advisor, Centers for Disease Control and Prevention
- Jim Macrae, MA, MPP, Associate Administrator, Bureau of Primary Health Care, Health Resources and Services Administration
- Tom Van Coverden, President and CEO, National Association of Community Health Centers
- Ron Yee, MD, MBA, FAAFP, Chief Medical Officer, National Association of Community Health Centers

**Ron Yee, MD, MBA, FAAFP:**

Good morning or good afternoon, depending on where you're joining us from today. I'm Ron Yee, Chief Medical Officer for the National Association of Community Health Centers and want to thank you for joining us for our national partner update as we continue to combine forces and align efforts with the CDC, HRSA/Bureau of Primary Health Care, NACHC, and health centers across the nation to address COVID-19. Again, just want you to know that we're all with you on the front lines and are seeking to support the health center movement in any way possible. Today, we'll be addressing an issue that's top of mind for our health centers, Managing Financial Insecurity During a Crisis.

**Ron Yee, MD, MBA, FAAFP:**

United, along with the help of the communities we serve, we've seen and we are able to flatten the COVID-19 curve in many cities and states, while others have or are experiencing surge situations. We're here to update the national context with our federal partners and to learn local solutions from our health center family.

**Ron Yee, MD, MBA, FAAFP:**

A few housekeeping items to start with. This is a voice only call, so there are no content slides for the speakers. The recording and transcript will be posted on the NACHC website. For those joining via the internet, you will see rotating slides noting aggregate figures from our PCA's and health centers. These are projections and estimates. Due to COVID-19 over the next six months, health centers across the country will have 34 million fewer visits, \$7.6 billion in lost revenue, and over a 100,500 jobs lost. NACHC and health center stakeholders are taking these projections to Congress to recommend at least \$7.6 billion in emergency supplemental funding to address the COVID-19 impact on health centers' day to day operations, staffing and care delivery, with a special focus on short and long-term funding for the overall health center program.

**Ron Yee, MD, MBA, FAAFP:**

Congress did respond to our initial request, for which we're very thankful, and took the first steps in providing a total of \$1.42 billion in emergency health center funding. But more is needed to prevent the deterioration of our essential health infrastructure in local communities and the decimation of the



country's health for generations to come. Access to health centers will become especially important in the pandemic recovery phase, as the number of unemployed and uninsured continue to increase at a rapid pace and as health centers incur costs for IT equipment as we shift to telehealth and virtual visits.

**Ron Yee, MD, MBA, FAAFP:**

To assist our health centers, our policy division just updated yesterday the Grants, Loans, and Other Cashflow Options document which you can find on the NACHC website or click on the resource button on the bottom left hand corner of your screen. Other rotating slides highlight what NACHC will be working on over the next seven days toward the fourth stimulus package and resources to help you with issues regarding health center workforce, operations, and finance slides. Slides will also give you instructions on how to ask questions, so please click on the questions tab, note to whom you would like to ask the question, and then type in your inquiry. If you want to chat with the other participants or communicate with the NACHC staff during the call, please use the chat function.

**Ron Yee, MD, MBA, FAAFP:**

Actually, in these last few calls, participants and NACHC staff cover a lot of the Q&A through the chat function, answering many questions that arise during the call. If you're having any technical difficulties, click on the Request Support button on the bottom left of the screen. Technical support staff will quickly get back to you. We'll group the questions around similar topics or themes to make our Q&A time more efficient and questions we can't get to will be added to the COVID-19 FAQs posted on the NACHC website.

**Ron Yee, MD, MBA, FAAFP:**

In order of our speakers today - we'll start with Dr. Lisa Koonin, Senior Advisor for the CDC COVID-19 Response Team, Centers for Disease Control and Prevention. Dr. Koonin will be joined by Dr. Tilman Jolly, MD, Lead, Tele-health HHS COVID-19 Response Team. Next, we'll have Jim Macrae, Associate Administrator of the Bureau of Primary Healthcare from HRSA. Followed by Tom Van Coverden, NACHC president and CEO who will follow Jim and he'll introduce Lathran Woodard, the CEO of the South Carolina Primary Care Association and NACHC Board Chair.

**Ron Yee, MD, MBA, FAAFP:**

Following our federal partners, will be Dean Germano, CEO of Shasta Community Health Center in Redding, California. He'll introduce his Senior Leadership Team and go deep into helpful details of Shasta's COVID-19 response from the clinical, operational, and financial aspects of the health center. Dr. Lisa Koonin from the CDC will begin our presentations. Dr Koonin?

**Lisa M. Koonin, PhD, MN, MPH:**

Thank you so much Ron and again it's such a pleasure to be joining you today for this call. I can't say enough how appreciative all of us are for your service, so thank you again.

**Lisa M. Koonin, PhD, MN, MPH:**

What I'd like to do with the time here is just quickly tell you about one updated guidance document and then I'll turn it over to Dr. Jolly. As you know, our infection control guidance is constantly being reevaluated. And as we learn more about this pandemic virus, we can update our guidance and we have done so on April 13th. I encourage you to look at the CDC website for this updated guidance. Predominantly featured is a change which is aiming to address asymptomatic and pre-symptomatic



transmission. And so, we recommend now implementing source control for anyone entering a healthcare facility. And that includes all healthcare personnel, patients, and visitors, regardless if they have symptoms or not. This action is a change from previous guidance, and it's recommended to help prevent transmission from effected individuals who may or may not have symptoms of COVID-19.

**Lisa M. Koonin, PhD, MN, MPH:**

We also recommend that the healthcare facilities actively screen everyone who enters for fever and symptoms before they come to work at a healthcare facility. And let me just point you to several other guidance updates that are posted with this infection control guidance on our website so that you can get more detailed information. So, I'd like to turn the remainder of my time over to Dr. Jolly.

**Tilman Jolly, MD:**

Thank you, Lisa, and good afternoon or good morning. I appreciate the time to speak with this group. It's really a vitally important group. I'm an emergency physician, still practice at times in the community and certainly am aware of the importance of what all of you do in maintaining the health of communities. I'm going to talk just a little bit about what we're doing within the FEMA task force structure and some of the major issues we're working on related to office space and health center practices. We have a number of task forces and we have the health care resilience task force. We just focus on a number of areas of preserving and maintaining the function of the healthcare system.

**Tilman Jolly, MD:**

Telemedicine has lots of touch points within that and fortunately there's been lots of things done to try to promote that and to help that along. We look at this in your setting first in sort of the obvious need to care for COVID-19 patients in and around your practice setting. Manage them, advise them. And as testing becomes more prominent, manage that testing and really avoid hospitalization and emergency department visits until absolutely necessary.

**Tilman Jolly, MD:**

You also perform a function we don't want to forget, which is maintaining the health of patients with other acute and chronic conditions, which we can't ignore and can't forget, less we end up with a much worse health situation a few months down the line and long-term. A number of things have come along to really support telehealth and they're all publicly available. CMS and others have issued significant guidance about reimbursement for telehealth, which was quite inconsistent before, but allowing particularly for federally qualified health centers to be sites for telehealth and allow a number of other waivers related to location of patient and location of provider to provide for that.

**Tilman Jolly, MD:**

Many states are now waiving licensing requirements. As you know, that's managed by the state and not by the federal government, but the federal government is also supporting telehealth, regardless of state or location of the state in which the patient is located. And another area that's important, and it sort of touches on a point that was made in the first remarks, relates to equipment and the potential need for equipment. As many of you may know, certain apps like FaceTime and others have not been designed for healthcare, but the office of civil rights has agreed to waive any penalties under HIPAA for use of these sorts of apps, for communications with patients, which can be quite effective in practice and telehealth in a very simple environment and really maintain those connections and some practices are doing very well at that.

**Tilman Jolly, MD:**

There's a lot of good news stories you really want to work on getting out and over the coming weeks we're going to be working with probably some of you and some others and try to really get the good news stories out about how people have enacted telehealth and put it into their practices. We've already had lots of meetings and webinars with many of the primary care and specialty societies that you and your positions are members of, the American Academy of Family Physicians, American Academy of Pediatrics, ACOG, and others, and some significant specialty societies that are promoting a lot of things for their members and they all have guidance available for their members that are some just generic to the practice of medicine and some specific for the needs of their specialties. And I encourage you to go to their sites.

**Tilman Jolly, MD:**

The other major resource I want to point you to is telehealth resource centers that can be found at [telehealthresourcecenter.org](http://telehealthresourcecenter.org). It's a collection of national telehealth centers, but you really don't have to just pay attention to the one that serves your region. There are national resources available and in fact they have call lines where people can get advice on how to bring telehealth into their practice.

**Tilman Jolly, MD:**

Now, it's no surprise that they've seen a 750% increase in direct requests, but those requests tend to be pretty general. The number one request is how do I start. And they are available to help you enact pretty simple procedures to get telehealth started in your practice to try to improve the volume, and improve the health, the care of your patients. I'm going to stay around on the call, as will Lisa, and we'll be available for questions and we certainly look forward to this. Thank you very much.

**Ron Yee, MD, MBA, FAAFP:**

Thank you Dr. Koonin and Dr. Jolly and to the CDC for giving us the technical expertise we need in this response. Thank you so much. We'll move next to Jim Macrae, Associate Administrator with the Bureau of Primary Health Care. Jim?

**Ron Yee, MD, MBA, FAAFP:**

Okay, so maybe Jim couldn't make it at this time. So, next we'll move on then to Tom Van Coverden, NACHC President and CEO. Tom?

**Tom Van Coverden:**

Ron, thank you very much and a big thank you to everybody. Mostly though all of you on the front lines that are doing it and all of us that are trying to support your state associations and the health center networks, etcetera. So just thank you for all that you're doing. We've been a successful so far. We're making a request for your first run, you referred to it, the \$100 million investment, then \$1.32 billion. So those total up to the \$1.42 billion. Our current request into Secretary Azar is for \$8 billion. It's actually a little bit more than was originally requested to deal with, again, the immediate massive shortfalls in revenue that health centers are facing. So, we hope to hear on that shortly. And when Jim gets on, he might be able to talk a little bit more about it. I know they're putting plans together now.

**Tom Van Coverden:**



Let me just say in addition then to the thank you. The time for enhanced action for us is now, not only what you're doing on the street and where people need you in your communities, but you hear the discussion now with the Triple T. The first one being is we're looking forward and testing a whole lot of people, many often, frequently. So, one, being able to Test and having the equipment to do that. The second then is to Track. And third, Treatment, hopefully by the time they develop the vaccine, be able to make sure that we're actively involved and aggressively involved in making sure that that piece is executed as well. So, Testing, Tracking and Treatment, the big areas in front of us, you know that better than anybody and that's what we need to be doing and that's where the nation is focused.

**Tom Van Coverden:**

So that's going to be over immediately. Let me just say in Congress, the next two weeks are going to be very critical and I said the time for action is now. I say that and later on we'll get into it. Mr. Clyburn, the majority whip in the House has been asked by the Speaker to put together the package for the fourth piece of legislation and he's made it very clear to us and later on we'll address that. The time for action guys is now in this fourth piece for you to put forward. You've patiently waited back and supported the other activities. So, the next two weeks will be very, very critical. And again, their package is being put together. So, I know that many of you have been doing articles and I thank you talking about what it's like in the real world, what your needs are in telling the story that way.

**Tom Van Coverden:**

Secondarily, we've asked all of our PCA's to work on getting letters with your state delegations, as was done in Massachusetts. And then thirdly, when talking here with your congressional folks and leaders and other public leaders at the state and local level, again, expressing support and asking them to get their letters and requests for support in dealing with the health center package that we put forward to Speaker Pelosi and Leader McCarthy on the House side. And on the Senate side, with Senator Schumer and Senator McConnell. Let me just say that again. The data that health centers have been reporting has been incredibly important. And Jim will be saying that. We've gone from 400 to 600 surveys. Now, the last reporting weekly on the number of active--1000, now the last set reporting weekly on a number of activities.

**Tom Van Coverden:**

What are we doing with regard to this virus? And now this last week, 1,154 have reported. And so, the challenge now is to add at least another 100 to 200 sites, reporting regularly on the number of patients seen, the number of people treated, the number of people identified, etc. All the data that's been asked for. I know it's greatly appreciated. That information is being carried up to the secretary and to other leaders within the department, to CDC and others, so that we can see where we need to have additional emphasis, where there are hotspots, and how we can work more closely and better with you. With that, I'd like to ask our leader, National Chairman, Lathran Woodard, to pick up for us.

**Lathran Johnson Woodard:**

Thank you, Tom. And I also want to just thank all of you for the work that you're doing and realize that we are all in this together. And we can weather this, although it may not seem that way at times. But we must stand together united, and I am going to quote something I heard from one of the presenters, Germano, Dean, from California. We need to be over communicating, which is what I didn't think was needed, but that's what's needed. And so that's sort of my new word now, over-communicate. Make



sure everyone knows, because the three point conversation, if you will, that I'm going to share with you, and that was obvious. We can't over communicate.

**Lathran Johnson Woodard:**

Quickly, Congressman Clyburn's office is calling me. I made the first call, of course, but then they've been calling me about giving them updates and being consistent with numbers. But the first thing I want to tell you, I learned that Clyburn was having a call with our governor and our state public health department, which is DHSC. And soon as I heard that, I get a call from DHSC, who asked what are health centers doing around this crisis, this pandemic we have?

**Lathran Johnson Woodard:**

Now I almost fell out my chair, because I'm like, "What do you mean? What are we doing? We are on all your calls." So, I pushed that aside, sent them a write up of what we had been collecting. And then after hanging up, I decided to call Congressman Clyburn and say, "Look, I understand that you're going to be talking to our governor and state public health, but I need you to know that centers are so far down on the line in terms of getting state support, especially around PPE and testing kits. And all the money in the world is not going to help us if we don't have access to the supplies.

**Lathran Johnson Woodard:**

So, ask one question during your conversation. From the national stockpile that DHSC got and that the state got, how much went to the centers? So, I said, "Please, if you could get that in." Long story short on that one, we get a call the next day from state public health office asking, "We want to meet with you as to how we can work better with health centers, and can you give us a list of what your PPE needs are?"

**Lathran Johnson Woodard:**

I said, "Okay, very interesting." And then Congressman Clyburn's office calls and asked me about us doing mobile testing. This is the second item. The mobile testing piece was presented, sounded like he was just looking at hospitals, because the entity he called was a hospital. And so, my antenna went up, and I said, "Whoa, whoa, whoa. Do you know health centers, if you are not specific in some of this language, we will again be left out? Although we're doing a lot of work, we aren't being recognized as I think we should."

**Lathran Johnson Woodard:**

And it's different from state to state, and I want to say that, but I was speaking for South Carolina at the time. So, if you're going to do some mobile testing, did you know our centers, several of them, already have infrastructures in place with their mobile clinics to do that? I don't know what else they need. I'm not clinical, nor do I have the finance piece, but I wanted to open the door, keep the door open that centers who are interested to be a part of this additional dollars he's trying to put out for tests, and especially in rural areas. And I told him to add frontier and also medically underserved populations. There shouldn't be a catch all.

**Lathran Johnson Woodard:**

He is steady pushing that. And mobile testing doesn't necessarily mean a mobile unit. Okay? So, it can be whatever. But that I wanted to say was very important because he then had a meeting of the half democratic caucus meeting, which was I think yesterday. And had asked for... I don't know whether he

asked or whom had asked, but had Dr. Stein, some of you may know who Dr. Stein is from Vermont, to actually speak on what she's doing around her mobile services. So, Tess Kuenning calls me, and we just want to make sure we are putting out everywhere possible the fact that we have centers who are capable of doing testing, and we should be recognized as first responders, because we are the front liners. And also, we need PPE and supplies.

**Lathran Johnson Woodard:**

So, in her talk with them, she stressed that as well. The third thing, which just really was a hard pill for me to swallow, was when the Congressman's office, specifically the majority of his office, sort of called me on the carpet, if you will, about what we're doing, and Lathran, "You know, y'all got it with the House, really. And we're going to fine tune. You're going to get stuff from the House. It's the Senate you need to worry about. What are y'all doing there? You need to cultivate some Republican champions in the Senate." And from our conversation, and this is her speaking from what she seen, that's your weakest link.

**Lathran Johnson Woodard:**

So, I kind of talked to her specifically about our two state senators, which both are Republicans, and she gave me some pointers, because she knew how to deal with them. And she also said, per Congressman Clyburn, "Be unapologetic about what you're asking for, because we all know the good you're doing. So, come out asking for what you need." And she compared it to what happened with the airlines, that the airlines got what they wanted. And when we even asked the airlines, "Are you going to be able to save jobs then?" Airlines said, "We're not promising that." And they still got the money. So it was, in her mind, I guess, the rub of we're giving this money to help save jobs, not just to maintain your profit margin.

**Lathran Johnson Woodard:**

So, what I want to end with is stressing, we need to cultivate our senators. And that is not NACHC staff's position. I think NACHC staff does a great job of picking out and targeting and saying, "Here are the key people, but it's us as PCAs, HCCNs, health center staff, the board, and never, ever think or limit what staff should be talking. We have one center that, one of our administrative assistants had a personal relationship with the Senator. And we were sitting back and saying, "Oh, we didn't know that."

**Lathran Johnson Woodard:**

So, we need to do more. Keep the message the same. The urgency of this. Keep the NACHC staff informed of what you hear from your Congressperson. How do they feel? What is it that they want to hear and want to know? What is it they don't like that we may need to fine tune? That is the over communication and continued communication that needs to go on.

**Lathran Johnson Woodard:**

We all are doing a great job, but we've got to stay the course and don't give up on that advocacy piece with the Senate, which the message has gone out, and I know NACHC has done that.

**Ron Yee, MD, MBA, FAAFP:**

Thank you Lathran and Tom, appreciate that. Jim Macrae was able to join us. Jim, I'm going to give you one or two minutes, because the crux of why I wanted to bring Shasta back is to give them time. So, Jim, if you have one or two minutes for some high level points, please make them.

**Jim Macrae, MA, MPP:**

Will do, and apologies for jumping on late. It's been a little hectic in terms of a lot of interaction at HRSA. I think as you heard from both Tom and Lathran, and probably you, Ron, health centers definitely are a focal point in terms of all of the work related to COVID, and definitely a lot of interest in terms of helping support you all, but also, as you can imagine, high expectations.

**Jim Macrae, MA, MPP:**

The two items, I just wanted to highlight this for, as you said, one minute, one with respect to the COVID-19 dollars as well as the CARES Act money that we just put out. I made it clear on our call yesterday, and we have another call scheduled for tomorrow, in terms of the use of those funds, the good news is we got an interpretation that the COVID-19 funds can be used to help support activities that maintain and increase health center capacity and staffing levels. That was something that many of you had asked, if we could see if we could come up with some interpretation that would help health centers use that first tranche of money to help with that piece. And the answer is yes.

**Jim Macrae, MA, MPP:**

The only difference now between the two funding sources is that the CARES Act money that health centers received can also be used for minor alteration and renovation projects, but otherwise, funds can be used for the same purposes. Please, I encourage you to sit in on our call tomorrow, where you can get more information about those two funding opportunities.

**Jim Macrae, MA, MPP:**

And then the last piece, I just wanted to echo something that Tom said, which was a huge thank you to all the health centers for submitting their data. As Tom mentioned, we had over 1,150 health centers that submitted the last summary report. We had 83% of all health centers reporting. In terms of the data itself, 82% now report that they have testing capacity. 44% have walk up testing capacity. Health centers tested more than 56,000 patients last week, and about 9,000 tested positive. On the sort of negative side, which I think you'll hear from our colleagues in the health center work realm, we definitely have seen a decrease in terms of the number of visits. About 47% is what we're operating at in terms of where we are right now. We have almost 2,100 health centers sites closed across the country. We've had about almost 1,400 staff that have tested positive for COVID, and health centers have clearly made the pivot to doing virtual healthcare, because now almost over 51% are conducting visits virtually.

**Jim Macrae, MA, MPP:**

So just wanted to provide those quick updates. That information will be up on our website we hope by tomorrow. It'll be there both nationally and a state level. And we will also have data from our Look-alikes. And a big thank you of course to our primary care associations for all of the data that they've submitted to us also.

**Jim Macrae, MA, MPP:**

So that's a quick update, Ron, and thank you and apologies for running late in terms of participating. Thanks.

**Ron Yee, MD, MBA, FAAFP:**

No, thank you, Jim, and thanks for that data. So yeah, thank you again to our federal partners, Tom Van Coverden and Lathran Woodard, as we really seek to align and support each other's COVID-19 response efforts. A few weeks back we had Dean Germano, CEO of Shasta Community Health Center and his Senior Leadership Team on the call, and at that time were not able to get to depth of discussion we were seeking. So, we're bringing them back today to go deeper into their health center operations as we seek to address managing financial insecurity during this COVID-19 crisis. Our objective is to really provide some practical input from the health center field, from Shasta Community Health Center, to help us get through this pandemic response. So, Dean, I'll turn it to you and your team.

**Dean Germano, MHSc:**

Thank you, Ron, and greetings to our colleagues from around the country. Again, this is Dean Germano from Shasta Community Health Center based in Redding, California. That's in far Northern California. Just as way of background, we take care of about 40,000 unduplicated patients, about a third of our county's population, and over 94% live below federal poverty. This is our third community wide incident in about two years. We were involved in the fires that consumed Paradise. We had another weather related incident. This is our third. Each one has its unique aspects to it.

**Dean Germano, MHSc:**

I would like to now turn it over to our Chief Operating Officer and our Incident Commander, Brandon Thornock to say a few words about how our incident command has worked.

**Brandon Thornock:**

Yeah, thank you, Dean. When I talk about our Incident Command Structure, I really categorize things into three, the three Cs. Clear expectations, Communication and Consistency. In terms of clear expectations, right out of the shoot, when you have an incident like this, you need to identify very early on who your Incident Commander is, who your Public Information Officer is, and the natural structure of a community health center really aligns itself well for this kind of a thing, because really, who's in charge of operations?

**Brandon Thornock:**

Well, your ops people. Your logistics. It's your procurement people. Finance, finance people. And so, in our health center, we identify myself as the Incident Commander, and Dean Germano is our Public Information Officer. So, he could be the voice of our organization amongst the community. The next piece is the communication, right? When you start something like this, you want to make sure that you communicate to all your staff. Make sure that they know who's in charge of what, what the structure looks like, what to expect, who to communicate to, that kind of a thing. Then we set up a number of different meetings, so that we could get immediate feedback from our frontline staff.

**Brandon Thornock:**

We could also communicate different initiatives that we've been rolling out. And so, some of the meetings that we set up in order to communicate, or over communicate as was mentioned earlier in the call, is we have our daily incident command meetings in the afternoon. This is where the Senior Management Group, the Incident Command Group, comes together and discusses what's going on. We debrief on the day and at that point we put together basically the information that we want to push out on a daily basis that Dean will then push out to all of the staff. Every morning we have a daily meeting

with all the clinicians. We use Zoom for that meeting and that's something that the Dr. Jeffrey Bosworth runs, as well as his deputies, CMO, Dorothy Bratton, so that the clinicians have an opportunity to provide feedback, share. We can give initiatives directly to them. And I have to tell you, that is such an important meeting because if you leave your clinicians out of this process, very quickly there's going to be some on the ground decisions that are made that are not in alignment with the overall goals of the organization and the initiatives that you have to push out. We found that to be essential and that happens every morning, every Monday through Friday.

**Brandon Thornock:**

Another meeting that we have is every late afternoon, Laura Doogan, who is our Deputy COO here, she has a meeting for all the operations managers, and this is very similar in nature. It's an opportunity for them to provide feedback. It allows Laura an opportunity to discuss any initiatives, that kind of a thing. All of those things together really help us over communicate and make sure people know what's going on and what the expectations are.

**Brandon Thornock:**

In terms of consistency, it's really important when you have this type of a structure and things are changing left and right that you document your processes. I know sometimes it takes a little bit of a time to get into a groove in terms of what your process is going to be, but once you've identified that you need to document those things. So, for example, telephonic and televideo visits, that's something that we added very quickly. Well, we documented, and once we figured out the details, we documented the process, we sent that out to folks so that we could have consistency out there on the floors. We also opened up a respiratory assessment center. That's where we assess all of the folks who are presenting to our health center who potentially have COVID based on their symptoms. We have now documented the process for the nurse, the processes for the clinician. That way we have consistency as they're fulfilling their roles and we're rotating different individuals into those spots. We also have implemented an administrator on call process where if we get a positive COVID-19 test, an administrator is on point to be called to then do the contact tracing. Well, there's a lot of steps in that and so we documented that process.

**Brandon Thornock:**

Again, it all comes down to consistency and the importance of documenting those things. So really that's our Incident Command Structure, how we structured it. Those are the three Cs; clear expectations, communication and consistency.

**Dean Germano, MHSc:**

Thank you, Brandon. Appreciate that. I'm aware that part of this discussion is managing financial insecurity and I just want to put a disclaimer out there that the fiscal realities are dictated in many ways by your state policies, particularly around issues such as Medicaid, the Affordable Care Act, reimbursement of health centers. And every state has a slightly different take on that. So, we're lucky in California, our state has been pretty generous to the health centers, but on the other hand, we take care of about 6 million people in our state. So, we're a major delivery system in our state. That said, everyone needs to manage the hand that's dealt to you. I know that's a reality for all of you.

**Dean Germano, MHSc:**

California had a stay at home restriction order that went into effect almost a month ago and almost immediately we saw more than a 50% drop in people attending coming into clinic, which makes sense under the circumstances. So that was the initial shockwave that hit us at that point. And I have to say from a policy standpoint through our PCA we advocated and received flexibility to convert patient visits from inpatient to phone or video visit, with of course proper documentation, to bill and be paid for by our state Medicaid agency at our PPS rate, which was a big plus. I have to say that was probably the biggest game changer we've seen. In some ways it's probably pushed our evolution in how we deliver care probably a lot further than where we were going previously, but huge, huge part of that.

**Dean Germano, MHSc:**

And now I'd like to defer to our Chief Medical Officer, Dr. Bosworth, as well as Charles Kitzman, our CIO, and anyone else on my team would like to talk about how we flipped the switch on this. We're now almost 50% of our visits are electronic. And I would say that many of my colleagues in California are almost up to 100% I don't know how you do that. We don't have the comfort to say that's the only way we can deliver services. But our area's not as impacted as some other areas with COVID. So, we've had the ability to make adjustments with a little more time than perhaps some of our colleagues. Dr. Bosworth.

**Dr. Bosworth:**

Thank you, Dean. Of course, like most health centers, our revenue and our ability to provide care depends upon individual patient visits. And so, when we had this major drop-off, we had to figure out a way first off, how we can continue to provide care, not just for patients that are presenting with respiratory symptoms and possible COVID, but their ongoing care for their ongoing medical issues.

**Dr. Bosworth:**

Dental is one area that is really impacted and so we're not able to telephonically or by video visits take care of dental visits. So, we still have dental services only for the most severe emergencies. But for all of our other types of visits, primary care, psychiatry, behavioral health, we are expanding into the realm of phone visits and video visits. And so, we've very rapidly developed our processes there.

**Dr. Bosworth:**

As a brief summary of how we do that, we basically have our front office staff either by protocol or with feedback from their providers, identify patients that are appropriate for a telephonic or video visit. Sometimes it's very difficult to provide appropriate care without that person being in place, for wound care for example, or anything that's a minor procedural or would need in office testing. It's hard to imagine how we can provide a meaningful visit by telephone or video. But we also, we wanted to significantly decrease the number of patients coming to our health center so we could have better social distancing and make our patients more comfortable. Some patients are self-selecting not coming to the health center because of fears of contracting COVID virus. And some of our providers are also concerned about seeing patients live because of their own health needs and that sort of thing.

**Dr. Bosworth:**

So, we really embraced this right off the bat. Very quickly we were able to start our phone visits. We identify the patients; their processes are very much similar to our previous live processes. The front office staff first processes the patients, their billing information over the phone and pre-registered them. They're put on the schedules. Nursing staff then will reach out to the patients and will process the

patients by going through the medication list, identify what the medical issues are, do screening questions and that sort of thing. And then the clinical team, which for us consists of the provider and the scribe, will in a private area, contact the patient either by phone or by video contact and they go through a protocol of identifying who's in on the call from either end, they verify the identity of the patient. And this is all documented in the chart. And then they conduct the visit to the best of their knowledge, best of their ability. And then that is documented in our regular processes through our EHR.

**Dr. Bosworth:**

It's been actually very well received by our patients. I think we're meeting the patients' needs. They almost universally are very appreciative of the ability to do this. And our clinicians have been actually really surprised at how comprehensive the care is that they can provide in most cases. They're getting very creative on assessing things over the phone that they didn't think that they could do beforehand. It's been very successful. Within a few weeks, we've gone to about 50% of our business are now by phone or video. We're using Doxy as a platform for video visits and we're ramping that up and so that can expand the type of visit we can do. So that's kind of our process. Anything to add there?

**Dean Germano, MHSc:**

Charles, from a technology standpoint, any lessons there?

**Charles Kitzman:**

Sure. Thank you, Dean. This is Charles Kitzman. I'm the CIO here at Shasta. I think really simply, preparation leads to separation when it comes to these things, and I'll speak briefly about two different areas. One is you have to prepare the environment. Our exam rooms don't have phones in them, so we had to mobilize phones into those rooms so that we could protect our patient's privacy and set our teams up for success. We did that in our main facility in a day and a half. We mobilized wireless bridges. We didn't know if we were going to be delivering services in our parking lot. There's no signal or network connectivity out there. We had to make sure that we were able to create the framework to have our people do their jobs successfully. And we've also benefited from having the space available to bifurcate staff and create the respiratory assessment center that Brandon mentioned earlier.

**Charles Kitzman:**

The other thing on the software side is we've leveraged data very effectively, not only to go after patients that have a high acuity or pose a high risk for COVID so that we can proactively reach out to them, we've also isolated other populations specific to different areas of our practice. For example, in Pediatrics, we were able to quickly create lists of patients that are asthmatic, that are on ADHD medications or have chronic allergies. Those types of visits bode well for telephonic or video visits. We've been proactively working those lists and using data at our disposal to be smart about who we're reaching out to and how.

**Charles Kitzman:**

Another software facet is that we have an agile platform, we're on the NextGen platform. Once we got guidance from the state on the consent and compliance and documentation requirements, we quickly developed a process that really the main goal was rapid development designed to reduce staff burden, and so a lot of the stuff that is required in this documentation, we automated it. We didn't want to have our staff have to remember every single rule every single time. By virtue of developing a good process



for check-in, creating visit types and whatnot, we created a lot of programming that cascades through the encounter and automates a lot of those documentation requirements, making it easier for our staff.

**Charles Kitzman:**

I think one other thing is that we've leveraged this Incident Command Structure onto our Intranet. We have a centralized, archived, and maintained area for all of our staff to be able to access any updates that come our way. That could be regarding PPE, masks, employee benefits, opportunities and everything like that, plus the daily briefings. And so just to reiterate, I think preparation really leads to the separation. I think we've done a good job thus far.

**Dean Germano, MHSc:**

Thank you, Charles, appreciate that.

**Dean Germano, MHSc:**

I just want to finish off a little bit on a few little things an organization can do to preserve cash. And at this time, as always, cash is king, but when you're not having the cash come in, you really have to manage it even better. One, if you haven't thought of it already, I'm sure most of you have, is how you manage your payables. We have a good track record in terms of paying our bills early actually, while we've decided to slow many of the payables down except for our local vendors who are really hurting. So, we try to be a little more up to speed with that. But it's something to consider. We have been really engaged in a 340B program. We were one of the first in the state to be involved in that and we benefited from that. And because of the cash that that generated, we did a lot of self-funding. We partially self-fund our health insurance, our dental insurance, our vision, even unemployment insurance and because of that, over the last several years we've saved several millions of dollars that would have otherwise gone out of the organization. And now we're using some of that cash to help us get through the moment.

**Dean Germano, MHSc:**

And the other piece that has really come to help us was our long standing relationship with the local regional bank. We've been dealing with a bank and we know them, they know us for almost 25 years. And when the Paycheck Protection Act came out, they were actually on task before we wrote to them in terms of getting our application in. And we have it in, and we heard Saturday night I got an email from the head of the bank that our application was approved. Now we haven't seen all the details yet, but those relationships do matter when it comes to these things. And of course, I'm sure a lot of you have those things.

**Dean Germano, MHSc:**

So, and lastly about engaging with your elected. As we heard today, whether it be local, your public health department, your statewide people, and certainly our federal officials and working through NACHC and your PCAs to help you with some of the cash issues and your mobilization issues. We still have challenges. We still have nowhere close to enough testing up here. We can't do drive by testing. We don't have that yet. We're looking forward to having some of that capability. We're managing it day by day. The anxiety of our staff seems to have dissipated. I think this over communicating has really helped. And I just want to say thank you to all of you out there doing the job. So that's our report, Ron.

**Ron Yee, MD, MBA, FAAFP:**



Thank you so much, Dean, and well, I appreciate that approach, all the way from the Incident Command Structure down to the clinical operational level, IT, and finances. So, thank you so much. This is so helpful to the field. We did want to take some time to answer questions. So, we also have joining us today to answer questions, Gervean Williams from our Training and TA Department. She is the Director of Finance. And then we also have Colleen Meiman, from our Policy shop, the Director of Regulatory Affairs. So, if there's any specific questions about frontline billing, which Shasta, of course, can answer, but if there's any more technical details we can ask Gervean to answer those, and then Colleen is available also. Ellen, we can go ahead and start with our questions.

**Ellen Robinson, MHS, PMP:**

Thank you very much. The first question is for the folks at Shasta. Many of our agricultural workers do not have internet access. Is there anyone who has developed strategies to reach these members and support their healthcare while maintaining social distancing?

**Dean Germano, MHSc:**

I can say, we're not a big Ag area, even though you might think so. We're in Northern California, but I'm looking at the team here and nothing's really coming to mind. Basic phone calling, cell phones are out there. That's probably our most effective tool with the small group of agricultural workers we do serve. I'm sure there's folks out there that are doing some innovative things, but I'm not aware of them.

**Ellen Robinson, MHS, PMP:**

Okay. We will keep looking for other people who might have some ideas that we can post on our chat. People were really, first of all, just a lot of positive comments about thanking everyone and our speakers, particularly today, for helping. A couple other questions for Gervean and Colleen at NACHC and this is about billing. Are testing at centers billable or is it considered preventative and not billable at this time?

**Gervean Williams:**

Okay, I'm still doing research on that because CMS just released on how people can test for COVID-19. After I do the research, I'll post it on our COVID landing page and in Noddle pod.

**Colleen Meiman:**

Sure, and this is Colleen, if I could add one point to that. I think there may be some confusion here about being billable versus being a preventive service. As a preventative service, that means that under a lot of insurances you can't charge a copay, but you still can certainly bill the insurance provider and get reimbursed for that. In fact, even if somebody comes to you and you don't have an agreement with their insurance provider, you can actually, they have to pay you anyway. There's something on Noddlepod about you need to have your prices publicly posted on your website, but you should definitely be getting reimbursed from the insurer, for anybody who is insured.

**Ellen Robinson, MHS, PMP:**

There's a couple other, really in today's topic about billing and finance we were getting a lot of questions and we really support our health centers and we feel for them. They're asking questions about how do they get paid? Does Medicare pay for telephone visits for the FQHC PPS rate?

**Gervean Williams:**

So, right now with the CARES Act, CMS said that health centers can be a distant site provider. I'm going to be really clear on the language on what telehealth is. Telehealth is the substitution for a face to face visit. There are other different virtual services, but for telehealth, that's what it is, a substitution for a face to face visit. My colleague, Susan Sumrell, and I are waiting to get more guidance on CMS on how health centers can bill as a distant site and they haven't posted that yet so as soon as that's posted and finalized, we will send that out to the field.

**Gervean Williams:**

And the telehealth for Medicare, it has to be an audio and a visual. It's not just the phone. It can't be a telephone. I know some state Medicaid agencies have loosened the guidelines around that, but for Medicare right now it's still an audio and a visual communication.

**Colleen Meiman:**

Although, I can add to that, that I know Susan Sumrell is working very hard with CMS to try to find some wiggle room so that they can loosen that up just to be audio. We're making the case that a lot of our patients are in rural areas without access to broadband. A lot of our patients don't have the devices at home necessary for a visual connection, and also just a reminder in the Medicaid world that is a state by state decision. There are some states where health centers get paid their full PPS for phone calls at a certain length. So, if that's not the case in your state, you'll want to work with your PCA and your state colleagues to work with your Medicaid agency.

**Ellen Robinson, MHS, PMP:**

Thank you. I think we have time for a few more questions. The next questions relate to patients getting to health centers. Are they allowed to purchase bus or taxi vouchers as well as phone cards for patients who have prepaid cell phones?

**Colleen Meiman:**

Gervean, do you know? I think so, but I can't say with certainty on that one.

**Gervean Williams:**

I'm sorry, could you repeat the question?

**Ellen Robinson, MHS, PMP:**

About people wanting to know if the health centers can purchase bus or taxi vouchers, as well as phone cards to help patients who just have prepaid cell lines?

**Gervean Williams:**

Okay, so depending, and I'm assuming you're talking about using grant funds. It depends on your grant budget. I know they're relaxing things on the supplemental funding, but if you're talking about for grant funds, you need to look at your grant budget and how you would align items you put on there.

**Colleen Meiman:**

But just, I can't speak specifically to everybody's grant application, but generally the statute includes enabling services like transportation as an allowable cost. So, it should be allowable if it's in your grant, but you have to put it in your grant.



**Ellen Robinson, MHS, PMP:**

Okay, and Gervean, is there an update on tele-visit video for 99213?

**Gervean Williams:**

Okay. So, when I'm speaking on reimbursement, I'm speaking in regard to Medicare because each state is different, but for tele-visits or, I'm putting in quotes, "virtual visits", that is not a substitution for face to face visit. That's a different reimbursement model. And you don't get your PPS rate for that. I'm drawing a blank on the rate, but you don't get your PPS rate for the virtual visit because that's a different service.

**Ellen Robinson, MHS, PMP:**

And as part of the Care Act, a few people have asked about using all their funding towards salaries or does it need to be allocated to other categories as well?

**Gervean Williams:**

So, BPHC has done a really good job of saying what you can and not use your supplemental funds for it. So I would refer you to the BPHC site to the webinars they're doing, and they're doing another one, I do believe this Friday, to go over what you can use those funds for, but it is very important for you to know what's in your H80 grant and then when you submit your spending plans for the supplemental funds, where are you putting those line items in?

**Ellen Robinson, MHS, PMP:**

Thank you. I just wanted to call out that there are a couple of resources listed at the bottom of your screen including the statistics that people asked for at the beginning that Ron was mentioning and there is also some updated information from materials that Colleen has updated from last week about grant loans. We will be updating the COVID-19 page with some additional resources and answering some of these questions. The ones that we aren't able to get to or are still trying to figure out, we will research it and get it to the right speaker and post it on the FAQs. Ron, back to you.

**Ron Yee, MD, MBA, FAAFP:**

Yes, thank you and thanks, Ellen. Thank you to the NACHC team behind the scenes that are processing all this and doing the Q&A, and thank you, Gervean and Colleen also, for your extra input. I especially want to thank the Shasta team. This is really the level of detail we've been looking for and I think most helpful to people in the field. So, Dean, thank you to you and your team. That was what we envisioned, getting down to that level of detail so that people have something to work with and get some questions answered. So, we really appreciate that. Again, we want to thank everyone for joining us and especially want to thank our federal partners, Drs. Koonin and Jolly from the CDC, Jim Macrae with BPHC, NACHC President CEO, Tom Van Coverden, and South Carolina, PCA Director and NACHC Board Chair, Lathan Woodard.

**Ron Yee, MD, MBA, FAAFP:**

Special thanks again for the great insights from the front lines from Dean Germano and his Senior Leadership Team. Dean is the CEO, Brandon Thornock, the COO, Dr. Bosworth, CMO, and Charles Kitzman, CIO. Really appreciate the detailed response you had and the way that all fit together from high level down to operational. So, we'll talk with you next week, Thursday, April 23rd at one o'clock



Eastern time as we hear from our federal partners and health centers, including details of how they are addressing their COVID-19 response. We will continue this discussion and drill down deeper each time. So, thank you again all for joining us. And again, I want to reemphasize, we are with you. NACHC is behind you. I thank the Bureau, the CDC, we're all behind you to support you and help you get through this pandemic. So, stay safe and healthy as we continue this COVID-19 battle. Take care. We'll talk next week. Thank you.