

**Leading in the Crisis: Flattening the COVID-19 Curve:
*Planning, Managing, and Caring for the Workforce Now and in the Future***

Thursday, April 2, 2020

1-2PM ET

Speakers:

- Margaret Flinter, PhD, APRN, Senior Vice President and Clinical Director, Community Health Center, Inc.
- Dean Germano, MHSc, CEO, Shasta Community Health Center
- Aaron Harris, MD, MPH, FACP, Clinical Interventions Team Lead, Centers for Disease Control and Prevention
- Seiji Hayashi, MD, MPH, FAAFP, Chief Transformation Officer and Medical Director, Mary's Center
- Jim Macrae, MA, MPP, Associate Administrator, Bureau of Primary Health Care, Health Resources and Services Administration
- Luis Padilla, MD, FAAFP, Associate Administrator for Health Workforce and Director of the National Health Service Corps
- 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 today. I'm Ron Yee, Chief Medical Officer for the National Association of Community Health Centers. Thanks again for joining us for this critical national partner update as we seek to focus on and join forces to align our efforts with the CDC, HRSA/Bureau Primary Health Care, the Bureau of Health Workforce, NACHC, and health centers across the nation to address COVID-19. Today, we're going to address issues health centers are facing regarding managing and caring for the workforce now and in the future. This includes health professional training in health centers. We're in the heat of this battle, but united, we can help to flatten the COVID-19 curve. First, I'd like to deal with some housekeeping items to start with. Again, this is a voice only call, so there are no content slides for the speakers.

Ron Yee, MD, MBA, FAAFP:

The recording and transcript will be posted on the NACHC website afterwards. You'll see rotating slides for those joining via the internet, which will give you instructions on how to ask questions. To ask questions during the panel's presentations or during the Q&A time at the end, please click on the bar that says click here to submit a question, note to whom you'd like to question to be directed and then type in your question. If you just want to chat with other participants or communicate with the NACHC staff during the call, please use the chat function. If you're having any technical difficulties, you can click on the Request Support button at the bottom left corner to receive any help. At the end, we'll try to group questions around similar topics or themes to make the Q&A time more efficient. Questions we can't get to today will be added to our COVID-19 FAQs posted on the NACHC website.

Ron Yee, MD, MBA, FAAFP:

The order of our speakers for today, we'll start with Commander Aaron Harris, MD, MPH who's been detailed from the CDC's Division of Viral Hepatitis as the lead for the Healthcare Systems Coordination Team for the COVID-19 response at the CDC. Next, we'll hear from Jim Macrae, Associate Administrator, Bureau of Primary Health Care. Tom Van Coverden, NACHC, President and CEO will follow. Then we'll finish with our federal partner updates with Dr. Luis Padilla, Associate Administrator for the Health Workforce and Director of the National Health Service Corps, HRSA. Dr. Padilla leads the Bureau of Health Workforce that administers over 40 workforce programs with a staff of more than 450 people and oversees the National Service Corps with a field strength of more than 1,300 clinicians nationwide. Following our federal partners, I'll introduce, and we'll hear from our colleagues on the front lines of the COVID-19 response from the health center field. We'll start with Commander Harris from the CDC. Please begin our presentations, Commander.

Aaron Harris, MD, MPH, FACP:

Thank you, Dr. Yee and thank you to the National Association of Community Health Centers for inviting me to talk to you today. First, I want to thank you all for serving on the front lines of this unprecedented situation. We have heard many positive stories from our community partners, delivering direct patient care to patients on the ground, and the last 30 days have really tested us all in ways that we never thought possible. I think we can all agree that we're no longer in a sprint but a marathon, which will require us to unify as a community to beat this pandemic. I want to start off by sharing with you some updates from the CDC. Cases and mortality from cases continues to increase. But as of last night, the CDC has reported 186,101 confirmed and presumptive positive cases of COVID-19, and 3,603 associated deaths. All 50 states, the District of Columbia, Puerto Rico, Guam, and associated islands, and U.S. Virgin Islands have reported cases of COVID-19.

Aaron Harris, MD, MPH, FACP:

On March 29th, President Trump extended the nation's Slow the Spread campaign until April 30th. Initially launched on March 16th, that's 15 Days to Slow the Spread, lays out the guidelines for a nationwide effort to slow the spread of it COVID-19. It calls for the implementation of measures to increase social distancing between people at all levels of society. This is a massive proactive preventative response to COVID-19 and it aims to slow the spread and blunt the impact of this disease on the United States. All segments of the U.S. society have a role to play at this time. People across the country are asked to stay home as much as possible and otherwise practice social distancing. This includes canceling or postponing gatherings of more than 10 people and closing schools in some areas is determined by local and state governments. It also includes special measures to protect those people who are most vulnerable to this disease. People who are sick are asked to follow CDC guidelines on recovering at home and follow the new guidance on when it's okay to interact with other people again.

Aaron Harris, MD, MPH, FACP:

There is no vaccine to protect against COVID-19 and no medication approved to treat it. Although numerous research trials are underway. There's a body of evidence based on about 200 journal articles that supports the effectiveness of social distancing measures both when used alone and in combination with other measures. Much of these data are outlined in CDC's Community Mitigation Guidelines to Prevent Pandemic Influenza, United States 2017. These recommendations work better when they are

implemented together. While these measures are recommended until April 30th, government leaders will continually reassess the status of the outbreak in the United States. It may be that these measures will need to be modified. This is a historic unprecedented outbreak, the likes of which we have not seen since the influenza pandemic of 1918. The White House task force on Coronavirus established a website, www.coronavirus.gov, as the centralized website for the federal government and CDC continues to maintain its website, the www.cdc.gov/coronavirus in addition to that.

Aaron Harris, MD, MPH, FACP:

I wanted to also alert you to some updates on the website. There's a new CDC COVID-19 homepage redesign. There's a new guidance for screening clients for respiratory infection symptoms at entry to homeless shelters that was posted. We updated people who are at higher risk for severe illness on the website and this was also socialized on a COCA (Clinician Outreach and Communication Activity) call on March 27th, which is also available online for anybody who's interested. We updated getting your facility ready and practice preparedness tools on the website under the healthcare facilities tab. And we posted new phone advice line guidelines for children aged two to 17 years or adults, 18 years or older with possible COVID.

Aaron Harris, MD, MPH, FACP:

And there's a script that accompanies this and accompanying decision algorithm with care messages that is harmonized with the bots that we have on the website under the symptoms tab. In addition, we updated strategies to optimize the use of PPE on the website and this includes updated guidance on how to don and doff PPE, and new N95 decontamination guidance. We also have a burn rate calculator that facilities can use to estimate their supply of PPE. That's it for the update from CDC, over.

Ron Yee, MD, MBA, FAAFP:

Thank you, Dr. Harris. We appreciate the updates and the CDC's expertise as we face this pandemic. Next, we'll hear from Jim Macrae from the Bureau of Primary Health Care.

Jim Macrae, MA, MPP:

Thanks Ron, and good afternoon and good morning as Ron said to all the folks out in the Midwest as well as on the West coast. Thanks again to NAC for sponsoring this call and really pleased that some colleagues both past and present are on the phone, Dr. Luis Padilla, and Dr. Seiji Hayashi, who used to be our Chief Medical Officer in the Bureau of Primary Health Care. It's nice to hear from you later, Seiji. I haven't talked to you in a couple of days. So anyway, in terms of updates from the Bureau of Primary Health Care, just a few things I wanted to highlight for you all. First, with respect to our website, I would just continue to encourage people to go to our website.

Jim Macrae, MA, MPP:

We have a set of frequently asked questions that we are updating almost on a daily basis now with new information. Just two things I want to highlight for you all related to the FTCA program. First, we are pushing back the deadline for the FTCA applications by an extra 60 days. And so instead of the applications being due in April, or actually in May, they will now be due in July. And so, folks will have an extra 60 days to fill out those applications. That application guidance should be coming out soon shortly and then as I said, you'll have an extra 60 days to be able to complete that and that was a lot based on

your feedback and so we really appreciate that. The second thing is that we did put out some frequently asked questions and some new policies related to particularized determination.

Jim Macrae, MA, MPP:

What we have been able to do working with our general council office is to create a generalized determination related to providing FTCA coverage to patients that are not normally seen in a health center. And so, it provides basically relief to all health centers from having to submit on a case by case basis, these individualized particularized determinations. For other folks on the phone, I know that may not make a lot of sense, but that's a whole process and I know the folks on the phone would be really pleased to hear that they don't have to send in those separate applications. There's now a blanket approval for those types of situations, so please take a look at our website for that information. With respect to the first hundred million that we've put out. I'm really pleased to say that a number of health centers have already begun drawing those funds down.

Jim Macrae, MA, MPP:

We do have the ability with the way we set up this funding to actually be able to track down to the penny what's being spent. We actually have about 5% of our health centers that have already spent almost 75% or even more of their resources to date. We are asking, and this is just a reminder that folks submit their very brief application in to us. Just need to submit a budget as well as just a brief, I think two page summary of what you are going to be doing with your resources, whether you've already spent them to date or what you plan to spend them on in those different categories of prevent, prepare and respond. It's really critically important that you get those in as soon as possible. We tried to make it as easy as possible, just a very quick application, but we do need that just to make sure that the resources are spent appropriately, and you all have plans to be able to do that so please just get that in.

Jim Macrae, MA, MPP:

I know you have a lot of other things, but we've tried to as best we could make it as streamlined as possible. And like I said from the very beginning, we wanted to get the money in your hands first and then do the other pieces, stuff and barrel in. The next piece, which I know most folks are very interested in is the \$1.32 billion. So, we are going to be making those resources available very soon. A lot of folks have asked how soon will that be? What I can share with you is that in terms of awarding the \$100 million, we did that within 18 days, the enactment of the law. We are anticipating that we will do it at least that soon, but likely sooner than that. And so, we will have that done within less than 18 days and hopefully much sooner and we hope to get that out as quickly as possible.

Jim Macrae, MA, MPP:

Similar to \$100 million, we're going to make that available immediately in your payment management system so you can begin drawing those funds down. You'll be able to use those going all the way back to January the 20th in terms of the resources. In terms of the categories of funding with this one, it is different than the first one. The first two is down similar and then the third one is different. The first category is again the whole focus around safety of the health center itself, both for patients and for staff. It gives you the flexibility and the resources to be able to do a variety of different things including purchasing supplies, setting up offsite or onsite in the parking lot or other ways of separating COVID-19 patients from other patients. We've heard of a number of health centers for example, that has set up fever tents within their parking lot.

Jim Macrae, MA, MPP:

So basically, it'll provide you with some flexibility to be able to do that, including the opportunity to be able to spend money on alteration and renovation to your sites. The second area is specifically related to supporting efforts around COVID-19, both in terms of testing, but also being able to treat individuals with mild and moderate symptoms and gives you the flexibility to be able to do that onsite or through telehealth. And then finally, the last category is maintain or increase capacity within your health centers to be able to provide basic primary care services. The intent behind this is to really help support health centers as many of you have already done and make the transition more to a telehealth organization, or in some cases, you all have almost created separate sites as we understand it, where you have some of your patients being referred to certain sites for COVID, and then certain sites for well patient care or well-baby care or to just deal with the basic chronic health conditions that our patients see.

Jim Macrae, MA, MPP:

And so, resources will be available to help you support activities to be able to bring back staff as well as to retain staff, as well as to potentially reassign staff to do different duties and support. So, we are going to do everything we can to get the money out. Many people have asked about, you know, how are we going to do the money? Are we going to do the money the same as we did it in the first round? The short answer is no, we are not. We're going to do it to a different formula and that primarily is going to be reflected by that last category being included, which is to maintain and increase capacity at health centers. And so, our formula will change in terms of how we approach awarding this money. And we do plan to use the same basic parameters of having a base amount, a certain amount based on a number of patients as well as a certain number of uninsured patients but we're going to get that information out as soon as possible.

Jim Macrae, MA, MPP:

The last item because I know I'm up on time, is with respect to the data. So, we've had about 65% of health centers have submitted their data into us. Really appreciate all the help that you all been able to provide to us in terms of providing that information and data. We have had some technical difficulties however, with the data itself, but I think as most of you know, we did this extremely quickly and so we've run into some issues with respect to the data integrity. We had a couple of circumstances where we had multiple people in the same health center submitting data and so it caused problems in terms of being able to do any kind of roll ups. We also did not know which data was with which health center or which health centers submission was accurate. And so, we've been having to do a number of different cleanup pieces with the data itself and I think we've corrected it on the system side to prevent those kinds of things from happening

Jim Macrae, MA, MPP:

But it corrupted the data itself. But I think we've worked through most of those. Someone was telling me that hopefully they will be all corrected by, hopefully the end of today and we will get that out as soon as possible because we know many of you are looking forward to seeing that information and we are too. The last thing I will say with respect to the data is that we've also heard from you that having this be every two weeks is too much. And so, we will go to a once a week survey with respect to all the things you're doing related to COVID. So that's it for me. I've already apologized to Ron and I'm going to apologize to you all.

Jim Macrae, MA, MPP:

I do have to jump off the call because I've got to do a couple of things both for the funding as well as the data so that we can get that out to you all as soon as possible. But again, just appreciate the opportunity to speak with you. As my colleague at CDC said, please know we know how hard it is and just the work that you all are doing and we are trying to do everything we can from where we sit to help support you, but please know we know how hard it is and that's why our team is working so hard to get you what it is that you all need as best we can. So again, just a huge thank you to everyone for everything that they're doing, and I'll turn it back to Ron.

Ron Yee, MD, MBA, FAAFP:

Thanks Jim and thank you for all your efforts there. We'll hear from Tom Van Coverden from the National Association of Community Health Centers, our president and CEO. Tom?

Tom Van Coverden:

I want to say thank you to everybody on the phone. And Ron you asked me to just address that a number of folks that I've been talking to have really said we don't understand sort of what the strategy is. And so, let me just try and summarize what it is.

Tom Van Coverden:

But first of all, to serve our members, you the folks on the phone. And that's in concert with our state primary care associations and the health center networks as well. And then secondly, to protect obviously our staff and your staffs and toward that end, our big goal is to coordinate with all the parties that we can so that we're jointly all working toward a common set of objectives. And so, with key governments on the phone today Ron, you're going to continue these calls I believe for at least the next month or so.

Tom Van Coverden:

But that's what the Bureau, primary health care with Jim Macrae Company with the Bureau of Health Professions, with the Center for Disease Control, with the National Institutes of Health with FEMA and such other agencies, government at state level and at the local level, again, with our health centers.

Tom Van Coverden:

So overall strategy to attack and work together in concert on this campaign with COVID. Which again is changing from the mitigation phase and will to the bridge phase going to transition to recovery. And so, the plan we put on the table has been multi-pronged, but I think Ron first and foremost again have filed with FEMA for recognition as priority providers is one of the first pieces that we did. And then secondarily again, all of the work with the Center for Disease Control and with Jim. And my great, great thank you on behalf of all of us to the agencies for working with us and in concert with us.

Tom Van Coverden:

Let me look at again when I talked about the multi-phased plan that we have currently pending before the Congress is a request for additional resources. I know when I talked with some folks, I think they understand the money would not have been there without the strong advocacy of the agencies on the phone and all of you is a as member organizations. And yes, we hear regularly, and Ron keeps us

advised, but all of our staff are working whether it's who the state associations or directly. And I know there are very significant funding reductions for many centers that are unable to do it. Many are dealing with crisis situations and overflow between the number of providers, the demand for services, the move to tele-health and the telephonic health and virtual.

Tom Van Coverden:

So, there's just many, many issues that you're dealing with. Toward that end then, our public policy position and we're working closely with the Congress and both sides of the aisle is a five-point plan. The first one dealing with number one and for the short term is the mitigation is additional funding to deal with the current crisis for a six-month period at estimated \$7.6 billion. Those figures are derived from our state associations and Capital Link and I thank everybody for their contribution in helping to assess just how deep the financial hit on this has been and is.

Tom Van Coverden:

The second part then deals with a set of policies, one to stabilize current services and expand care to 10 million people. \$41.9 billion request will be made, and it would be made this afternoon specifically to Congress, which is now working on the fourth package headed in the house side of Mr. Clayborn from South Carolina.

Tom Van Coverden:

Much thanks to our national cheerleader and for you and Yvonne and all of our folks, Roland and our friends, Susan, and all of our friends in South Carolina. He knows the health centers personally. He knows what they're doing, he knows what they're up against and that they've got to be a significant part of the fourth recovery. So, toward that end again, the third piece is the workforce programs. Dr Padilla will be talking with you about whether it's a national health service Corp and a loan repayment program. The teaching health center programs, the Nurse Corps loan repayment programs and funding for the SUD training of healthcare professionals. Again, we are requesting \$7.8 billion in additional funding over the next eight years. And lastly \$20 billion over the five years going forward on infrastructure investment which includes building up the systems, doing the tele-health kinds of things. The capital needs that health centers have.

Tom Van Coverden:

Again, all of that is going out to our entire membership in a letter this afternoon. It was approved by our executive committee and we will be sending that out.

Tom Van Coverden:

Two issues dealt with also in there is one on tele-health with regard to adequate reimbursement. Again, a letter to CMS and we'll look for language in the current legislation which requires payment after the prospective payment rate title 1902 M to be in the case of Medicaid, so that it's adequate reimbursement to cover the actual cost of doing the service and likely to protection on the 340B funding.

Tom Van Coverden:

I know Ron, that's very, very quick, but I think staying on top of it, staying on top of the members, what their needs are. Again, the agencies we're working with have been very responsive, and responsible. I

say a huge, huge thank you. And I ask our members in terms of what exactly are you facing, what do you need, what do you see estimated cost, how can we help you? Who else can we connect with? And I think there's a lot of teamwork going on. So, my big thanks to everybody and happy to answer any question when the time comes. Thank you, Doctor.

Ron Yee, MD, MBA, FAAFP:

Good. Thank you, Tom. And thanks to the policy team. There is a summary of that 1.32 how it's being distributed and broken out on the NAC website. So next we'll move to Dr. Luis Padilla from the Bureau of Health Workforce and the National Service Corps. Dr Padilla, were you able to reconnect?

Luis Padilla, MD, FAAFP:

I hope so. I hope you can hear me okay.

Ron Yee, MD, MBA, FAAFP:

Yes. You're here. Thank you.

Luis Padilla, MD, FAAFP:

Yeah, I just got bumped off. Sorry about that. But thank you. Thank you, Ron. And thank you to NAC and Tom and others for the opportunity for us to join the call today. We are extremely grateful for this opportunity and I hope it's not the last but the first of many opportunities that we're going to have to connect with your health centers across the country. And so, what I'd like to do just briefly is to share some of the things that the Bureau of Health Workforce is doing to support the response to COVID-19 pandemic. But more importantly, use this opportunity, this first opportunity to hear from you, the front-line providers that are providing care across the country to our most vulnerable populations.

Luis Padilla, MD, FAAFP:

So, it really is just a brief update on our part and then really more of a listening session if you will. BHW is currently working across HERSA as you know. Jim mentioned the funding that obviously he's trying to deploy, but kudos to him and other leaders within HERSA or bringing in the workforce component. We're currently working within our current appropriations. As you know, the stimulus three didn't provide any significant additions to our funding, so we're having to utilize our current funding and it really speaks highly of Jim's leadership and other executives in the agency who are working collaboratively with us to address as best we can, workforce issues currently. But we are working across the department as well. And we're also working with the FEMA task force and the White House on workforce response challenges and opportunities. So, this role is fully in line with our mission, which I'd stated before is to improve the health of underserved and vulnerable populations, strengthening that health workforce and connecting skilled professionals to communities in need.

Luis Padilla, MD, FAAFP:

And now with this epidemic well underway, this is more important to make sure that we're connecting those professionals to really where they're needed the most. So, in this role, we're really focused on the following. I just want to give you our broad workforce objectives that the Bureau of Health Workforce is

working within HERSA and other agencies across to actualize. The first is protecting health professionals. Now while the Bureau of Health Workforce doesn't disseminate PPE, it doesn't disseminate testing kits. We're looking at every avenue to support whatever efforts are underway and whatever efforts we have within our purview to protect health professionals across the country, we continue to stress the importance of doing that. Not only because of the potential life loss there, but the disruption to services that can occur when you have an ill provider or sadly if you lose providers. So that's of utmost important to us.

Luis Padilla, MD, FAAFP:

The second one is identifying and implementing whatever programmatic flexibilities that we currently have, whether it's a national service coordinator score or any of our grant dollars, our grant funds, to identify any barriers that are being encountered currently because of the crisis and quickly act to implement any changes in those programs that allow greater flexibility.

Luis Padilla, MD, FAAFP:

The third is to expand capacity of our current workforce as much as possible. And what I mean by that is identifying areas where we currently have resources that would allow an expansion of health workforce in areas where they're needed the most. We're looking at things like utilizing students, partnering with organizations such as the double AMC, the A&A and other organizations that represent training schools and to see what flexibilities we have to mobilize safely students, but also identifying other health profession areas where we can spread our resources across where they're most needed.

Luis Padilla, MD, FAAFP:

The third is to support current clinical services, and certainly this is an area that you're touched by most acutely. As [BITPIC 00:28:43] starts to roll out its funding, we want to ensure that we're supporting the ongoing services that are needed right now. That could take a form in terms of supporting clinicians who are beleaguered, who are facing burnout, who are quite honestly are having signs of what you might characterize as PTSD. This situation is quite grade in many areas across the country. We've already had hundreds of providers, health care workers who have already been lost to this epidemic and we anticipate unfortunately that we'll lose many others. So, it's critical for us to make sure that we're able to deploy as many resources as we can to support our current complement of health workers across the country. And this extends well beyond health centers. We look at this as sort of the prehospital workforce, the hospital workforce and the post-hospital workforce. We're looking for opportunity to support.

Luis Padilla, MD, FAAFP:

The next component is data research, and what we're principally focused on is making sure that decision makers where they're internal to HERSA, BHW or outside of the agency, they have the most accurate, timely information about workforce data. They're able to visualize that, they're able to utilize it for planning and policy development. And ultimately any decisions that need to be made in terms of health workforce resource allocation, we want to make sure that those decision makers have the best available data and research at their disposal.

Luis Padilla, MD, FAAFP:

So those are the main components broadly speaking of our objective. While advising the larger federal response, we recognize that there were immediate things that we could do to help our program participants and grantees, including sites and providers and the National Service Corps and Nurse Corps program. So, I just wanted to highlight some of the immediate flexibilities that we've identified and already conveyed to our field strength and our health centers across the country.

Luis Padilla, MD, FAAFP:

In terms of the National Service Corps, Nurse Corps members, we're allowing them to serve where they are needed the most without having to worry about whether or not they're going to be in compliance where there are service requirements. So specifically, we're allowing participants to provide telehealth services at the direction of their sites, allowing more options for working away from their home sites during this public health emergency. We've posted this information online. We'll provide the link again. And we've sent messages to our field strength and site point of contacts. So I'll flag for you that immediately following this call from 2:00 to 5:00 PM Eastern time, your National Service Corps, Nurse Corps providers and site representatives are going to have an opportunity to connect in real time and ask us questions and get more information about program flexibilities during this emergency.

Luis Padilla, MD, FAAFP:

We're also looking to increase our flexibilities as I mentioned with our workforce grantees. The majority of our grants are medical nursing and other health professional schools, but like many, like our THC GME graduate medical education programs and our residency programs are directly connected to health centers, and we already have introduced flexibilities that allow grantees to deploy those clinicians to COVID-19 related clinical activities and remove any barriers that might prevent providers from serving where they're needed now to respond to this crisis.

Luis Padilla, MD, FAAFP:

And finally, BHW is looking to the longer term, and I think Tom mentioned this in terms of recovery. We're obviously very sensitive to the fact that we have immediate needs right now, but we're taking every opportunity to signal that in terms of workforce, we're really starting to look at what we're going to need, not just now in the immediate but mid-term and then long-term. The sad reality is that we went into this crisis with a shortage of providers, key providers, particularly in rural and underserved areas. It's very likely that that shortage is going to be exacerbated by this crisis.

Luis Padilla, MD, FAAFP:

So BHW is planning some immediate, very quick turnaround research projects to study the impact of COVID-19 on the current and future health workforce that serving in rural and underserved populations. We're also going to be deploying a survey out to the National Service Corps to better understand the impact of COVID-19 on a field strength and sites and are planning new programs aimed at addressing clinician resilience and supporting and promoting clinician wellness, particularly during this crisis.

Luis Padilla, MD, FAAFP:

And finally, I want to mention that we have extended the National Service Corps Loan Repayment Program deadline, now it will be May 21st it was going to close in April, but we've extended it to May 21st. Understanding that under this crisis, the structures aren't necessarily in place for all our clinicians to complete those applications. So, we've extended that and we're also looking to extend potentially the scholarship deadline as well to get more of those students' opportunities to complete those applications.

Luis Padilla, MD, FAAFP:

So, the loan repayment change is going to impact their ability to meet the loan repayment deadline, the rural communities LRP. And so, we encourage you to continue to get the word out. We're going to blast that out. I believe we made that change yesterday or the day before. So, we're going to communicate to our field strength that that deadline has changed to allow more opportunities for applications to be completed.

Luis Padilla, MD, FAAFP:

So, I'll stop there and before I end, I'll just say thank you all from all the BHW staff. We thank you for your heroism, your dedication to the communities we serve. We know that your systems right now are greatly strained, and we looked to having ongoing discussions in the near term on how we can better address your needs. Thank you.

Ron Yee, MD, MBA, FAAFP:

Great. Thank you Dr. Padilla, and to your team. Appreciate your efforts. So again, want to thank you, say thanks to our federal partners and Tom Van Coverden as we seek to align and support each other in this response. At this time, I'd like to introduce our colleagues from the health center field. They'll share what they've learned and are experiencing on the front lines.

Ron Yee, MD, MBA, FAAFP:

To follow up from Dr. Padilla's comments about workforce. We'll hear from Margaret Flinter, PhD APRN who serves as the Senior Vice President and Clinical Director of Community Health Center, Inc. Margaret is a family nurse practitioner and is the Chair of the Board of the National Nurse Practitioner Residency and Fellowship Training Consortium.

Ron Yee, MD, MBA, FAAFP:

We will then hear from Dr. Seiji Hayashi, family physician and as Jim mentioned past Chief Medical Officer for the Bureau. He also serves as the Chief Transformation Officer and Medical Director at Mary's Center in Washington D.C.

Ron Yee, MD, MBA, FAAFP:

And finally, we'll join a real time senior leadership meeting at Shasta Community Health Center, Redding, California, led by CEO Dean Germano, who's been with them for over 28 years. This team has unselfishly agreed to let us join their senior leadership meeting as they discuss their health center operations amidst the COVID-19 response.

Ron Yee, MD, MBA, FAAFP:

So, we'll start off with Margaret, please begin us, Margaret.

Margaret Flinter, PhD, APRN:

Great. Thank you so much. And hello everyone and thank you for asking me for feedback from the field about the impact of this pandemic on training in community health centers.

Margaret Flinter, PhD, APRN:

I want to start off by saying that today as I speak, my own NP residency team is in the middle of a seven-hour virtual consulting meeting with 49 leaders and their academic partners who are all planning to launch postgraduate NP residency programs this summer and early fall. They are moving ahead full speed and I think that is great and positive news.

Margaret Flinter, PhD, APRN:

Our own program here at CHC is in its 14th a year and we are well through our recruiting process for next year as well. So, we called and talked to a number of program directors around the country to see what the impact was and found it really, pretty remarkably similar to our own.

Margaret Flinter, PhD, APRN:

My first and most overwhelmingly consistent impression is that health centers and their training program directors are maintaining their 100% commitment to doing everything they can to ensure that amidst all the disruption, their trainees are continuing to get a solid training experience with much of it, now, of course, through the once in a lifetime, I hope, lens of responding to a pandemic. And I want to applaud all those health center leaders, in a crisis that requires your attention and where your staff and financial resources are deeply strained. It might've been easy to turn away from that focus on training, but you didn't. You incorporated the trainees right into the organizational response while still honoring the curriculum.

Margaret Flinter, PhD, APRN:

The only frequently cited adverse impact to NP residency training was the loss of access to some of the scheduled specialty rotations that take place outside of the FQHC. As we know, all the organizations have ratcheted down the people they're allowing to come in from other organizations and that happened there as well. But I think those hopefully will resume before the end of the training year.

Margaret Flinter, PhD, APRN:

I want to focus on what I see as the dramatic and positive news, which is the speed and quality with which health centers, including their NP residency training programs are pivoting to tele-health. These health centers either have or are creating the policies and the procedures, the protocols, and the communications to make this work orderly, high quality and safe and to train the NP residents to this model of care as well. I will tell you because I read the journals from all over the country every week, these new NP residents are really valuing and embracing this model.

Margaret Flinter, PhD, APRN:

What about next year? All programs are in the process of finalizing their recruitment, as in the past they're seeing stellar candidates. But none of us know what the coming months are going to bring. I personally have a lot of concerns of what can happen between here and there, particularly for those programs that don't have any external funding support right now because we know that organizations are really being stressed financially.

Margaret Flinter, PhD, APRN:

But I think health centers that have the programs are recognizing the additional value that these NP residents bring and I want everyone to remember these are boarded, licensed, privileged primary care providers, so in addition to everything else, they're also providing critical surge services at their health centers in COVID testing and screening and in triage. Our own NP residents are joining their NP colleagues who are usually in their school-based health centers, but those are now closed with the schools. They're joining them in staffing COVID related adult and pediatric related triage lines.

Margaret Flinter, PhD, APRN:

In our own organization, we're getting an average of 250 additional calls per day over baseline from patients who need to speak to a provider. They're complicated and time consuming calls and with NPs taking them, they can become a formal tele-health visit with diagnosis, treatment, assessment, and ordering of any necessary tests, which is a huge clinical contribution that adds to the ability to meet surge demand and it's a financial contribution to the practice as well.

Margaret Flinter, PhD, APRN:

Let me wrap up because I only had a few minutes here by saying that I want to note that our NP residents are also focused on leadership and quality improvement and those same reflective journals that I've referenced a few minutes ago, make it very clear that just a few weeks into this new world and after all of our collective, I think bumpy starts in those first few days, they are deeply impressed with the sense of teamwork, commitment and leadership, the way those early bumps and issues were resolved and the absolute commitment to staff, patients, and communities they're witnessing.

Margaret Flinter, PhD, APRN:

As one of the NP residents from Indiana said in a reflective journal this week, "There is just no other place I'd rather be and no other team I would rather go through this with." And I think that's the sentiment everywhere. We at Community Health Center, Inc., and the Weitzman Institute are here to support training programs up and running and those in development. You can find all our material at chc1.com or go to our Weitzman Institute. Thanks so much for a few minutes to talk with you.

Ron Yee, MD, MBA, FAAFP:

Thank you, Margaret, and for leading charge for our nurse practitioner residency training and their service in health centers. So, we'll move on to Dr. Seiji Hayashi, to show us just some frontline things that they've found that work. Dr. Hayashi.

Seiji Hayashi, MD, MPH, FAAFP:

Thank you very much, Ron. Things that work. I would have to say that the learning curve has been super steep over the last few weeks. We've made some mistakes. And I'd have to say that the lack of our ability to test patients and our staff has really put us behind the eight ball because now we are finding out that patients and staff have been exposed and some have come back positive, as well.

Seiji Hayashi, MD, MPH, FAAFP:

So just to set the stage and the context, I want to, because I'm going to talk about what we were trying to do to keep our staff safe. Mary's Center has been around for about 31 years as an FQHC, and we currently serve about 60,000 individuals in the D.C. Metro area. We serve a large immigrant population from Latin American and Africa. We have about 700 employees providing primary and specialty care, behavioral health services, dental care, comprehensive enabling, and social services. We also partner with a public charter school called Bria and they run an early childhood program, adult education, as well as two professional training programs. And they are co-located with three of our clinic sites. And so, we have five full-service integrated clinical sites and, as I mentioned, three are co-located with the public charter school. Two senior service centers where we see over 100 seniors a day. And then we also operate a school based mental health program at 23 District of Columbia public schools.

Seiji Hayashi, MD, MPH, FAAFP:

So, with 700 employees and we're probably like a mid-size community health center, but keeping our staff healthy is our number one priority and it is really, really challenging. And without our staff we can't help our community. So, it's paramount that we keep ourselves and our staff safe and healthy.

Seiji Hayashi, MD, MPH, FAAFP:

So, we've come up with, and I think that all of you have already come up with these two main strategies for keeping people safe. The first is to minimize in-person visits by maximizing tele-health. And then two, separating if you have to see patients to make sure that you separate the sick people from the non-sick people.

Seiji Hayashi, MD, MPH, FAAFP:

I'll go over really quickly the two. So, in terms of minimizing in-person visits, we have consolidated our five clinics into two. And we do have one small clinic open for pediatrics and OB in one of our most vulnerable neighborhoods because the need there was so great. But what we developed is sort of a six to eight-week rotation for our providers so that each provider is going through a three-phase rotation. First in a non-respiratory clinic for a week, followed by a respiratory sick clinic for a week. And then they will have four to six weeks of tele-work. And again, so the regular non-respiratory clinic for a week, followed by respiratory or sick clinic for a week, and then four to six weeks of virtual care. This is to make sure that after having the highest risk work environment, they have two weeks of virtual care followed by another two weeks or more, so that they can feel comfortable with their families. This rotation really does space out the risk and gives people ample time to recover and to ensure that they're not exposing others and that they themselves are well.

Seiji Hayashi, MD, MPH, FAAFP:

So, in order to sort of make sure that the tele-health piece, the virtual piece is working well, we've been doing tele-medicine for the last three years, especially where medical assistants were going out to the houses and doing tele-video visits. However, now with the relaxing of some of the HIPAA and BAA rules, we've really quickly moved into using voice and video, everything from Zoom, MS Teams, Doxy, Google Voice, and whatnot to make sure that people can quickly access virtual care.

Seiji Hayashi, MD, MPH, FAAFP:

We really transitioned very quickly once we decided around three weeks ago to go virtual. Within two or three days we were at about 75% virtual care. And depending on the discipline, for example, adult and family medicine for adults we are over 90% virtual. OB and prenatal care, that's a tough one. We were probably a lot lower than that. And pediatric is somewhere in the middle.

Seiji Hayashi, MD, MPH, FAAFP:

Payment has really been great in the District of Columbia where Medicaid and its managed care organization are allowing equal payment for voice, video, and in-person. So, our PPS rate is maintained.

Seiji Hayashi, MD, MPH, FAAFP:

Just to go through the workflow of how this works, we have for the virtual care, we have registration or operations staff confirm appointments as either a voice, video, or in-person and then the medical assistants remotely from either a clinic or from their homes do the intake, will do everything that we normally do in clinic other than vitals. Then through, we use the Microsoft Teams application throughout our organizations to text message and do other communications. Through the messaging the MAs will tell their providers that a patient is ready, that everybody is on the electronic health records. We use ECW and we can seamlessly do the care as if we were all together.

Seiji Hayashi, MD, MPH, FAAFP:

We also have tele-warm handoffs through video and voice with integrated behavioral health, social services, nutrition and health education, where if the clinic, whether it's through three-way calling or if we are seeing the patients in house, we will get the integrated behavioral health therapist on Microsoft Teams introduce the two, and then they can have a virtual visit moving forward. But the IDH, social services, nutrition, and health education staff are all virtual.

Seiji Hayashi, MD, MPH, FAAFP:

If we do have to see patients in-person, we actually have separated our respiratory and non-respiratory patients. We screen everybody at the front door. Even if they have a non-respiratory related complaint that they're coming in for, if they have cough, fever, and other symptoms there are actually sent to the respiratory or sick clinic. There is no mixing of patients and staff from the respiratory clinic to the non-respiratory side.

Seiji Hayashi, MD, MPH, FAAFP:

If a patient goes to the respiratory side and we find out that their issues are really not respiratory and they're deemed safe, they still stay on that side. We do everything we can and then send them home with a follow-up for a tele visit. And it's just to make sure that there's no cross-contamination that goes on.

Seiji Hayashi, MD, MPH, FAAFP:

We have also set up a tent outside our clinic for testing and evaluation. 95% of our testing and evaluations occur in this tent, never coming into our building. Even if our respiratory clinic side is secluded from the rest of the clinic, we actually, I mentioned that we partner with our public charter school, we are now using the charter school classrooms and offices as clinical space.

Seiji Hayashi, MD, MPH, FAAFP:

We also have stopped walk-ins. Any walk-in is immediately converted at the door to a tele-visit appointment and they are followed up. And so, then nobody is coming to the clinic without first having had a tele-visit.

Seiji Hayashi, MD, MPH, FAAFP:

The other thing that I think is going to make a huge difference in terms of keeping our staff safe is that not only do we screen all patients, we screen all staff, and then we also offer masks to all staff and all patients. And as you know, by having a mask on, that reduces the risk of exposure to low or minimal, and therefore we've done that.

Seiji Hayashi, MD, MPH, FAAFP:

And as I mentioned before, all meetings and most visits are now facilitated through electronics.

Seiji Hayashi, MD, MPH, FAAFP:

And so just in closing, we're an important part of keeping people out of the emergency room. And so, we are now working with EMS and the hospitals to try to figure out how do we not only keep people out of the hospital, but at the same time, as they come out of the hospital, take over their care.

Ron Yee, MD, MBA, FAAFP:

Thank you for those practical steps. Really appreciate it. Thank you for doing that. And finally, we're going to go to Dean Germano in California with his team to take up probably the last bit of time we have here. So, go ahead, Dean.

Dean Germano, MHSc:

Okay, good. So, shout out to all my colleagues around the country. I feel for you, I know what you're going through and thank you for what you do. Just by way of very brief background, Shasta Community Health Center, we're in far northern California, about 160 miles north of Sacramento. We've had the benefit of having a little planning time compared to some of you in the cities, in the big cities, and even

though California has been hit hard, we're only starting to see some of that come up our way. Our first community acquired infection happened just the other day. We have cases out there.

Dean Germano, MHSc:

We're doing a lot of what Dr. Hayashi's doing as well in terms of prescreening, setting up a respiratory care center, trying to do as much as we can with tele-visits.

Dean Germano, MHSc:

This is unfortunately our third disaster response in about two and a half years, the fires, and then we had something called Snowmageddon which took out about a third of the trees in our community and caused a localized disaster, and now this, which is very different. So, we're getting pretty good at incident command structures these days unfortunately, and that's what we essentially did, is created an incident command process where, in our case, our chief operating officer, Brandon Thornock, who's here with me, is the commander.

Dean Germano, MHSc:

And just some things to be aware of. We have 40,000 patients in the practice, about a quarter of the population. A lot of the low-income folks of our community, 90% of our patients are below federal poverty. We have a residency program, we have a MPPA fellowship program. We have all those training components that were talked about earlier and we're putting everybody to use as much as we can.

Dean Germano, MHSc:

I would say that one of the biggest lessons for us, and something somebody told me a long time ago is, at a time of crisis when you're talking with your staff, because ultimately care and attention of your staff is so critical when it comes to the care and attention of your patients, is that you have to over communicate, and not overwhelm them, but make sure that there's opportunities for them to be heard.

Dean Germano, MHSc:

I'll give an example, Dr. Bosworth, our chief medical officer who's here with me, at 7:45 every morning does a Zoom meeting for his medical staff and some of our center managers. Every morning at 7:45. We want to know the pulse of what's going on in our various sites with our staff, with our medical staff, get questions out there, try to get ahead of any rumors or concerns, and that has been very helpful in kind of keeping our critical leaders informed, essentially.

Dean Germano, MHSc:

We also do, well, we have a command center meeting in the afternoon where we bring all our data together, including PPE and other kinds of concerns. We do that. Our deputy COO does her own Zoom meeting with the clinical managers of things at the end of the day that we've learned.

Dean Germano, MHSc:

So we do that, and then at the very end of the day, I do an incident command bulletin to all staff and my board on all the relevant events that are happening, just not only internally, but external to us from the meetings we've been attending with hospitals and public health. For example, we have a surge meeting

this afternoon that we'll be attending because we've been notified, we're going to be getting a field hospital coming into the community, and so what is our role in relation to helping to support that?

Dean Germano, MHSc:

So, I'd just like to pass it on, technology has been really very important. If we're all discovering, talk about a paradigm shift happening really fast. We've been lucky in the sense that like some of your states, our Governor, our HHS director secretary has liberalized some of the policies around seeing patients via telephone and teleconferencing. We are moving more into the teleconferencing now over the next week, using, I think primarily Doxy. Doxy.me is the platform because we've tested it and found that it is probably the most practical for us. And so, technology has been very, very critical to us, but we're very sophisticated that way. And my chief information officer, Charles Kitzman is here with us as well.

Dean Germano, MHSc:

So, we have all these moving pieces. We're doing the screenings at the front door; we're promoting the telephone visits. It's been a little slower than Dr. Hayashi's folks over there, but we saw a 50% drop-off in face to face visits without us doing anything. People just stopped showing.

Dean Germano, MHSc:

So that was a real wakeup call right at the start, but we are quickly evolving to this. Interestingly enough, most of our clinicians have embraced it, some of our older doctors are having a harder time with it because they need to see that patient, right? So, there is some negotiation that has to go on about when that's appropriate and when not. So, I know Dr. Bosworth, you wanted to say something about the medical staff in all of this.

Dr. Bosworth:

Not much more, but it is something that communication is really important. There's a wide range of comfort level of some of the medical staff and we have to be flexible with that and respect their personal situations. We have a volunteer set up for people that are willing to participate in evaluating those at higher risk and we actively are separating those patients out from the rest of our practice to protect our staff and the patients and to keep our other operations running.

Dr. Bosworth:

We've actually closed one of our sites across the street from our main facility that was a psychiatric facility. We're moving those activities elsewhere and we're going to make that our sick area for all of our patients to be funneled to and where we can do a better job of keeping those patients isolated, but still evaluate and treat them.

Dean Germano, MHSc:

Yeah. And I'm looking at Brandon or Laura, did you want to add anything to what we're doing?

Brandon Thornock, Shasta Community Health Center:

Yeah, I would just add one thing. You know, what we're finding is that a lot of patients are deferring their lifesaving medical care at this point. They're suffering in silence at their homes. They're afraid, and

so we've been very aggressive about reaching out to them through texting, social media and other avenues to try and encourage them to call us and establish a telephonic appointment.

Brandon Thornock, Shasta Community Health Center:

We also have conscripted a number of our dental staff who, unfortunately we've closed all of our dental facilities except for emergency care. They're actively reaching out to patients and a lot of our high-risk patients so that we can get them tucked in and provide them the care that they need during this time. You know, part of that is a bit of a self-preservation strategy. Up here on a normal day, we're pretty overwhelmed with the daily demand that's out there, and we're worried that once the dust settles and this pandemic subsides a little bit, then we're going to get a huge tidal wave of demand that's going to be extremely overwhelming to our system. And so, by being aggressive and proactive at this time, we're hoping to avoid that.

Dean Germano, MHSc:

Yeah, and I would say that again, our state has been very helpful. For example, we have a lot of dual eligible patients in our practice, about 20% of our practice is Medicare, and of that, about 15% of the 20% are dual eligible. Medicare has been not as quick to respond to moving to telephone visits in a way that Medicaid has in many states, but our state said for the dual eligible, they will provide us a wraparound payment for those folks despite what Medicare may or may not do.

Dean Germano, MHSc:

So again, I know a lot of you are in states that have governments that are working with you and others that are having a harder time, but we've been very fortunate in that respect. So, I give credit to our PCA and our colleagues across the state and as well as our Governor.

Dean Germano, MHSc:

Anybody have anything else to add? I would say one other thing. We've been very pleased with the response on the federal side with HRSA in particular. We've had to move sites around. We had to deal with 340B. Everybody has been lightning fast in getting these things done for us and giving us that flexibility. So, I shout out to them for understanding the need on the ground and making sure that, you know, bureaucratic barriers aren't going to get in the way of us doing the right thing. And that's what I said to the staff, when in doubt, do the right thing. So, anybody else have any... Yeah. Okay. That's it.

Ron Yee, MD, MBA, FAAFP:

Thank you for sharing your senior leadership time with us Dean and the team. We appreciate you. You know, I think your frontline experiences are what people need to hear about and how to shift around, especially if you're early in the response. So really appreciate all you've shared with us.

Ron Yee, MD, MBA, FAAFP:

We don't have time for Q&A because we added a few speakers, but we wanted to get that information to you all. We will address the Q&As and put them on our website. I want to appreciate everyone's time and just review a couple of points before we finish up for today. We will be back next week. We're going to focus on special populations, but a few things I think are important for you to know on the front lines. In addition to giving input to Congress regarding the \$100 million and then the \$1.32 billion going to



health centers, the policy team is continuing to provide input, as Tom said, looking at stimulus package number four and making sure health centers are in there.

Ron Yee, MD, MBA, FAAFP:

We're also seeking funding from other sources to support the COVID response from foundations and philanthropic groups. Yesterday, our team met with 80 funders highlighting the selfless and unrelenting work you all are doing on the front lines to serve our communities and to let them know about what's going on in the health centers and to fund the efforts.

Ron Yee, MD, MBA, FAAFP:

Also wanted to inform you that there's a critical memo on the NACHC website, Synthesizing and Outlining Options to Assist Health Centers, PCAs and Networks, addressing cashflow issues. This is really important to keep things running. This includes an overview of items such as paycheck protection loans, emergency paid leave, economic injury disaster loans, pandemic unemployment coverage, advanced Medicare payments and the \$100 billion dollars for healthcare providers under the CARES Act.

Ron Yee, MD, MBA, FAAFP:

Dr. Padilla and his team, as he mentioned, are going to start an office hour, flexibility FAQ office hour immediately after this call regarding the National Health Service Corps and Nurse Corps. So, you can find the link in the left-hand corner under resources. You can find it there and go immediately to that webinar and office hour.

Ron Yee, MD, MBA, FAAFP:

Again, I want to thank everyone for joining us today. This is an important time for us to join together and I want to thank our federal partners, Dr. Harris from the CDC, Jim Macrae with the Bureau, Luis Padilla from the Bureau of Health Workforce, and the NACHC team with our president and CEO, Tom Van Coverden. And especially I want to thank the insight and information from the front lines from Margaret Flinter, Dr. Seiji Hayashi and Dean Germano and his leadership team up in Shasta, Redding, California.

Ron Yee, MD, MBA, FAAFP:

And we'll talk to you next week as I mentioned, Thursday, April 9th at 1:00 PM, and we'll address the nuances and particulars of serving health center special populations amidst our response. So again, thank you all for joining us. We are with you. So please stay safe and healthy as we continue this COVID-19 battle. Protect yourself. Stay well and on the front lines. Take care everyone. We'll talk with you next week.