Leading in the Crisis: Flattening the COVID-19 Curve:
Dental Innovation and Services
Thursday, April 30, 2020
1-2PM ET

Speakers:

- Ramona English, DMD, Chief Dental Officer, Petaluma Health Center, Petaluma, CA
- 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
- Alan Mitchell, Executive Director, HealthEfficient
- Kathie Powell, MSHA, MA, Chief Executive Officer, Petaluma Health Center
- 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:

Thank you for joining us for our national COVID-19 call today. I'm Ron Yee, Chief Medical Officer for the National Association of Community Health Centers. Our national partner updates continue as we align efforts with the CDC, HRSA/Bureau of Primary Health Care, NACHC and health centers across our nation in our COVID-19 response. Seeking to be responsive to the needs we're hearing from health centers and the health center field week by week, we are here to support the health center movement. We've gotten a lot of feedback from the field asking about dental services, which have been reduced to emergency-only encounters. This has resulted in the dental staff being redeployed to other health center functions or has led to layoffs or even staff being let go. So today, we'll address dental innovation and services. We'll hear from a health center from Petaluma, California, who's implemented some innovative approaches to dental care.

Ron Yee, MD, MBA, FAAFP:

We'll also hear from a Health Center Controlled Network regarding their response to COVID-19 and the part they can play. We will provide updates from our federal partners and then local solutions from a health center family member. A few housekeeping items we'll start with; one of our speakers, Alan Mitchell, from HealthEfficient Network has slides that he'll be using today, so you'll see those on screen. They're also downloadable, if you click on the Resources button on the bottom left of the screen. 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 question to be directed and type in your inquiry. If you want to chat with other participants or communicate with NACHC staff during the call, please use the chat function. If you're having any technical difficulties, click on the Request Support button on the bottom left of the screen and the technical support staff person will quickly get back to you.

Ron Yee, MD, MBA, FAAFP:

We'll group the questions around similar topics or themes to make our Q&A time more efficient towards the end of the call and questions we can't get to will be added to our COVID-19 FAQs posted on the NACHC website. To review our speakers for today, we'll start with Dr. Lisa Koonin, Senior Advisor for the COVID-19 response team, Centers for Disease Control and Prevention. Tom Van Coverden, NACHC

President and CEO will follow. Next, we'll have Jim Macrae, Associate Administrator, Bureau of Primary Health Care, HRSA. and then following our federal partners, we'll hear from Alan Mitchell, Executive Director of HealthEfficient, a New-York-based Health Center Controlled Network. Alan has slides that will be under our Resource tab that you can download, just to remind you. And finally, we'll hear from Kathie Powell, CEO, and Dr. Ramona English, Chief Dental Officer of the Petaluma Health Center, Petaluma, California. Dr. Lisa Koonin from the CDC will begin our federal updates.

Lisa M. Koonin, DrPH, MN, MPH:

Thanks so much and it's always a pleasure to be on this call with you. Let me, once again, thank you for your service. We know that you are saving lives on the front lines and we were very grateful for that. A couple of things in the works that I know that you'll be interested in hopefully will be published on the CDC website in the coming days. One is the Return-to-Work Guidance for Healthcare Providers. That has been updated and is in final stages of development and will be posted very soon. Also, know that we're working very hard to put together reopening guidance and guidance for healthcare facilities for resuming clinical functions. We're working on that right now. That will be posted also, we're hoping in the next week or so. This week, we posted a COVID-19 serology surveillance strategy and this strategy describes that CDC is working with state, local, territorial, academic and commercial partners to better understand COVID-19 in the US. We have an overarching strategy for learning more about how many people have been infected, the virus that causes COVID-19, and how it's spreading through the population.

Lisa M. Koonin, DrPH, MN, MPH:

This strategy not only uses a diagnostic testing strategy, but also a serology testing for surveillance. And we're looking for antibodies in the blood that had been developed after someone has developed an infection. The seroprevalence surveys that CDC is conducting are many and they include large-scale geographic surveys, community-level surveys, and smaller-scale surveys. The objectives for the strategy are to provide a more complete estimate of how common COVID-19 is for the population and also to guide control measures such as social distancing. You'll find on our website more about this information.

Lisa M. Koonin, DrPH, MN, MPH:

Let me just say that there are many questions still unanswered that we want to answer through serology survey, such as how many of the US population have been infected? How is this changing over time? The characteristics and risk factors associated with SARS-CoV-2 infection, how many people have experienced mild or asymptomatic illness and how long antibodies can be found in COVID-19 infection. We know that some people who were tested may not exhibit positive serology even after they've experienced an infection. It may be to their immune system. It may be to the length of time between the onset of illness and the timing of the serology tests. There's still a lot to learn about this and I'll be happy to answer questions at the end . I'm turning it back over to you, Ron.

Ron Yee, MD, MBA, FAAFP:

Thank you, Dr. Koonin. It's good to know the CDC is looking at all these angles. There are a lot of questions health centers have every day as we try to figure out our strategy, locally, but also on a national basis. Appreciate that and we will continue to be in contact with you. Next, we'll move to Tom Van Coverden, President and CEO of NACHC, to give us a NACHC policy update. Tom?

Tom Van Coverden:

Ron, I want to first say thank you to you and to everybody on the front lines in the field, our partner primary care associations, Sherry, Carmela, the leadership team, Amy and the networks. Jason is the chair of that, again, and what could we do without CDC and HRSA, as well as other key government agencies? A big thank you to everybody. Ron, let me just try and focus. I think everything that, at least what I see in talking to so many centers, that you're doing is also what we're doing by way of what is it that we need immediately, what do we need to do immediately? And as we're transferring, what is it we need to do for the longer haul, the future looking forward? I like it. As one of our directors said, "Tom, we're doing what we were planning to do over the next two years in two weeks." I still like to quote that one. God bless you all for what you're doing.

Tom Van Coverden:

We already have the money that's been allocated and we thank HRSA and everybody for that. The $1.4 billion and I think Jim will probably be talking about the additional $600 million they're looking for on the allocation of for that funding. Jim can address that and the HRSA staff. On our side of the fence, what we're trying to do is still look for an additional $51 billion that is out there and available, especially for the Medicaid and uninsured populations. Again, we'll be continuing to make a strong case to get that funding to try and get it into many of the health centers, the public health and social services emergency fund.

Tom Van Coverden:

And then, of course, what is in the process of being drafted right now and looked at, the pieces being put together over the next two weeks is what we call, again, the stimulus package number four of which the Speaker has asked Congress to put together a package and we have submitted the piece for $77.3 billion to include some more temporary funding, to stabilize the programs, the reauthorization for the five-year period. Again, workforce-related funding and then funding for really carrying forward the program and developing new and innovative approaches to care; what it is you're doing, where do you need additional resources to do that?

Tom Van Coverden:

Ron, that's the overall game plan. Let me just say, looking forward, number one, I talked about the funding, where we stand, what we currently have, what it is that we're working on and trying to answer a number of questions that the Congress and other folks have. For example, in many of the bills we've put money in, we have shown health centers we're able to tap into that. Aside from the money specifically targeted, how much for what have you been able to get and what then additionally do you need? We ask for people's help in trying to get and working to get HRSA good information and data and numbers related to that. I think that's the first category. And again, looking forward then, how do we get the additional funding in there to both hire staff back?

Tom Van Coverden:

A number of people we've talked to have said, "Tom, the money's helped a lot and we appreciate NACHC and all they're doing, but for me it's only two or three months' worth of funding to continue operations at a time when we're being asked to significantly increase our testing abilities," only for our current patient load, 30 million, but going beyond that to work with our local governments primarily and also our state governments to do additional testing when and where it's required in priority areas and

priority populations. I think that's what many of you and we're trying to be a part of that, working with you and the state associations. What is it that the needs are out there and what else can we do?

Tom Van Coverden:

Let me just point to ... Jim, I have if people don't have it, but for example, I come into Massachusetts and New York and I know several other states are doing daily command center COVID-19 updates; number of patients seen, number of tests given, amount of contact tracing that's going on, assistance with long-term care facilities, plans with schools for current populations of kids and coming back in for regular immunizations. Again, there's so many pieces of data that are being put forward. If we could get that going in each and every state, I think it's just incredible and it helps all of us better understand what others are doing and so that we might replicate that as we're looking forward to what in the future, as well as sharing that information with the federal agencies that have to be responsible for what are we doing, what are we not doing that we could be doing and, again, working together to try and tackle that going forward.

Tom Van Coverden:

Let me just say in a second area ... number one is resources. Number two deals with workforce. I talked about it, again, workforce, where are the shortages we currently have? I know that we've had to close over 2600 sites currently. We talked about the dental staff. Somebody had mentioned earlier you're going to talk a little bit more about what is the need that's out there currently and what can we do to both bring back, hire back and then, looking for the forward part, what additional things is it that that we need to do and what funding do we need to do it? And so specifically, we mentioned in part of our proposal in tripling the size of the National Health Service Corps loan repayment program. I would note, again, and say that Dr. Padilla who heads the agency, the Bureau of Health Workforce, has indicated that only 40% of the eligible that which was applied for last year, which was short, less than half of what was available of the thousand clinicians and physicians that were available under that and the applications.

Tom Van Coverden:

Now, I think everybody understands that the centers are busy, busy having to readjust budgets dramatically, whether it's layoff, whether it's hours, whether it's setting up virtual health and how that's being done, what else they're doing. A lot of stuff going on, but with all that said and done, again, over the course, I think it's still three weeks left, maybe Jim will announce it, but not to miss the opportunity, especially for those with low HPSA scores. Perhaps the state agencies were not able to get the information and in time, but again, we talked about the shortage of clinicians and the eligibility. This is our chance to really take advantage and maximize that and it certainly speaks to what we'll need going forward by way of, again, doctors and nurses and others.

Tom Van Coverden:

So that's part of the current plan. Stepping into the future, what is it then additionally we need to do, as well as our legislative proposal, which calls for greater flexibility and base increases for health centers. It's got a five year plus 10% will build capacity and help us transfer to technology, to virtual, to IT staff, to other staff that are needed and flexible dollars, as well as share information, innovative models and things that we're doing, again, with our clinical staff and resident training, teaching health centers and other programs. And thirdly, just for NACHC's side of it, I think working with, again, our partner primary care associations, what are we doing, for example, to communicate with each other in our meetings?

Tom Van Coverden:

And we've all had to operate differently. And so, we've had to cancel a number of our major meetings; the Agricultural Conference of the Policy and Issues Forum, the Community Health Institute, recently, I believe we'll have to cancel. The board of directors took a long, hard look at that and talked about the pros and the cons. Could we, couldn't we? Would California and San Diego be open? What alternatives are we looking at? And I think pretty much have made a decision, which we'll be announcing shortly, that we'll have to cancel the actual meeting. With that having been said and done, what we're looking at is doing virtual meetings, trainings, and technical assistance and what we'll be able to do to continue a part of the conference in the communication, which I think everybody feels is so important. Sharing information and stories, etc. I know they're a major revenue impact for all of your organizations, as there is with NACHC we have to look at and how we're doing that going forward.

Tom Van Coverden:

Ron, I think it gets back into also, for example, looking at real areas just beyond this short crisis. How do we reimburse for telehealth services, again, and virtual services? And much of the care which will be delivered that way while we're going through the testing and isolation of certain sets of folks, and yet not being able to diminish our regular healthcare that we're delivering. And again, I mentioned the kids going to school. That was the first question the Secretary has said. What is our plan for doing that? Ron, so I know maybe a lot on there, but as we're all trying to move from here and now what do we need to be doing today, next week and next month? And then looking toward the future, what are the things we need to shift and move our focus to and emphasis on? So that's the game plan for the moment.

Ron Yee, MD, MBA, FAAFP:

Great. Thank you, Tom. And thank you to Steve Carey and our Policy team for you guys being on the Hill, representing our health centers and getting funds to help things out. As Tom mentioned, the National Service Corp application deadline has been extended. That's to May 21st. So, May 21st, you have three weeks. Please get those in because you still have to think forward to what's going to happen after COVID, so please do get those in. Next we'll move to Jim Macrae from the Bureau of Primary Healthcare. Jim.

Jim Macrae, MA, MPP:

Thanks Ron and good afternoon and good morning to everybody on the phone. Thank you for joining us today. We know you continue to be on the front lines of responding to COVID, and just really want to thank you for everything that you're doing. Just to hear the stories really is remarkable, and we know it's not easy in terms of what it is that you all are doing, but just a huge thank you to begin.

Jim Macrae, MA, MPP:

Also, want to thank our colleagues at NACHC as well as our colleagues at CDC and of course the health centers that are participating in presenting today. I'm actually really glad that we're talking about dental healthcare today. It is an issue that has definitely been impacted in terms of the operations of many, many dental practices across the country, but we are starting to see a little bit of light at the end of the tunnel.

Jim Macrae, MA, MPP:

Just recently in Virginia they announced that they're going to open up more routine dental care services and it's definitely, I think, going to be needed in terms of the needs of our patients and needs going

forward, but I also know that probably the way we provided dental care needs to likely change in response to COVID-19. My brother-in-law is actually a former dentist and he was talking to a lot of his colleagues and even the way we probably provide dental care will need to change and adapt given the new realities of COVID-19, at least for the foreseeable future as we begin to provide routine services again. So just a huge thank you to the folks who are presenting today and a huge thank you to all the folks who have been involved in dental care. It is a key need of our health center patients and we'll continue to be going forward.

Jim Macrae, MA, MPP:

I have just a couple of things that I wanted to share. First and foremost, just wanted to put a plug in for application, so of course if you have an opportunity, I encourage you strongly to apply for those national health service core providers, as both Ron and Tom talked about, there is an incredible opportunity here. We also know it's incredibly challenging, given revenues and sources of funding and other things, but it is an opportunity that doesn't come along very often for health centers to be able to go much further down the list in terms of being eligible for those national health service core providers. So please consider that.

Jim Macrae, MA, MPP:

The second thing is that we have our applications due for the second COVID money that we put out, the $1.3 billion, so those reporting instructions and progress report pieces are due May the 27th, so please turn those in. We've received almost all of the reporting information that we needed for the first supplemental that came out. We're following up with a few health centers that still needed some extra time to put those in, but please put those applications in. It's critically important to get those submissions so that we can work with you if there are any issues or any concerns, and then of course give you permission to continue to move forward. So, May the 27th, put that down on your calendar. Please make sure you get those applications in.

Jim Macrae, MA, MPP:

The next thing I want just to highlight is we did get our next round of testing data in, so a huge thank you to the folks that participated. We had over 1000 people that submitted the data, so again, we're at a good level. About 75% of health centers across the country submitted information for that data.

Jim Macrae, MA, MPP:

The good news is that the number of weekly tests has gone up. It's over 80,000 tests that are done on a weekly basis, so some really great information there. We also have found that the average turnaround time for COVID-19 tests, about 65% of health centers are getting those results within 24 hours or less. And so that's a good sign, but that means that about 35% it takes longer than a day and so we know that's been a concern with many health centers out there.

Jim Macrae, MA, MPP:

In terms of the other statistics, we're still finalizing the data. We hope to have it up on our website very soon. Shortly we'll have the breakouts for testing by race and ethnicity, both in terms of the number of tests that are completed as well as the number of folks that have tested positive. The other high level data is remaining about the same.

Jim Macrae, MA, MPP:

Health centers are operating at about 53% of their pre COVID-19 weekly visit numbers, so still having a significant impact there. The number of staff that are unable to work has gone down slightly and so that's a good sign. It's down to about 12% And as we've heard, as different folks begin the process, different states begin reopening we know that health centers will begin that process too, but definitely in a changed environment in terms of how they're going to function and operate.

Jim Macrae, MA, MPP:

The next thing I wanted to touch just with respect to testing is that, and Tom mentioned this also, we have $600 million available for testing to expand the capacity of health centers to do testing, but also to expand the capacity of FQHC Look-Alikes to do testing. I think as I mentioned last week, we were very happy that this next round of funding that health centers are receiving will be available to both health centers as well as FQHC and Look-Alikes. So that's really good news. I know a lot of Look-Alikes have been looking forward to receiving those resources, so we're very happy about that.

Jim Macrae, MA, MPP:

We hope to be able to get the money out for testing very soon shortly. Most of you know, that's catch phrase that we hope to be able to get that out very soon, shortly. For the FQHC Look-Alikes it's going to take a little bit longer. We will have to go through an application process just because we don't have a formal grant relationship with you all, so we have to go through all the different grant mechanisms. There will be an application that comes out. You'll likely have a couple of weeks to be able to submit it in through grants.gov. We will do a very quick review and then hope to get the resources out to you as soon as possible, so stay tuned with respect to that. I know many of you are very anxious about that. Just bear with us as we work on the Look-Alike side.

Jim Macrae, MA, MPP:

And then finally, I know a number of you have been asking questions about the Provider Relief Fund. The one thing I just want to draw your attention to is that, and we sent out a bulletin about this yesterday and I'm sure the folks from NACHC also have that, the first $50 billion that was distributed through the general fund is starting to go out the door. The first $30 billion already has gone out and now they're beginning to distribution of the remaining $20 billion. And the most important thing I would just say is that for any health centers that already received a payment from the Provider Relief Fund, you are now eligible to apply for additional funds by submitting data about your annual revenues and estimated COVID related costs to the Provider Relief Fund application portal. So please, if you have received a payment, go into that portal and fill out the information that's needed in that general distribution portal.

Jim Macrae, MA, MPP:

If you go back to yesterday's program bulletins, you can have a direct link to that. I know it's also on the Provider Relief webpage.

Jim Macrae, MA, MPP:

For providers who have not yet received any payment from the Provider Relief Fund, you do not, and you should not, go into the general distribution portal. So that's just a clarification that we put out. So more to follow, more information will be provided on the Provider Relief Fund as those other funds start to go out the door. So that's it for me, Ron.

Ron Yee, MD, MBA, FAAFP:

Thank you, Jim. And thanks again to our federal partners and Tom Van Coverden as we seek to align and support each other's COVID-19 response efforts. These webinars, our objective for these calls is to provide practical input from and for the health center field and to help each other deal with our pandemic response.

Ron Yee, MD, MBA, FAAFP:

My heart's warmed to see all of our dental folks on today in the chat room. I want to say a special welcome to our National Oral Health Associations and dental groups, including our Chief Dental Officers, dentists, dental hygienists, registered dental hygienist, and dental staff. So, a special shout out to you all and thank you for what you're doing on the front lines.

Ron Yee, MD, MBA, FAAFP:

So next we'll hear from Kathie Powell, CEO, and Dr. Ramona English, Chief Dental Officer of Petaluma Health Center, Petaluma, California. So, Kathie.

Kathie Powell, MSHA, MA:

Hi. Yes, thank you for inviting us to speak and share our experiences. They have been the same, I think, as everyone else in community health and we're so excited to really be in this field right now and taking care of our whole community.

Kathie Powell, MSHA, MA:

We have about 35,000 patients, just to give you an idea of the size. And we have been able to convert about 85% of our visits to video and telephone visits. And we did that rather quickly. I'm not sure how we did it, but we just worked around the clock and everyone pitched in and we have great teams and were able to do that. And so really then the only types of visits we couldn't do are the chiropractic visits, acupuncture, and vision visits. And then of course a lot of the dental visits, which Dr. English will talk about in a few minutes. She has figured out how to do some video visits with dental, which is really exciting.

Kathie Powell, MSHA, MA:

And so, with doing that, we needed to send most of our staff home, and so they're working from home. We have about 85% of our staff members working at home. And that, again, was a challenge because of all the computers and laptops that we needed, but a lot of them took their workstations home and we were able to get a couple of hundred laptops. People are home working and we've only had to furlough about 4% of our staff, and most of them were in the dental department. And then of course a couple of chiropractors and acupuncturists and optometrists.

Kathie Powell, MSHA, MA:

And then, what else are we doing? We are reaching out to our patients a lot. We have a lot of mental health and behavioral health visits that are done where we actually reach out to the patients who we know probably need us the most and we have re-stratified our patient population and estimated who needs the most help from us reaching out to them for clinical services as well.

Kathie Powell, MSHA, MA:

We've taken a population health approach to that and reached out to the people who are at highest risk of having COVID and made sure that we brought them in for testing, if that was needed and just reached out to them to make sure that they had everything that they have. And all of our patients with chronic diseases we've been following are our quality measures, which we are measuring 75 different measures and reaching out to all of our patients that we know are important to keep in touch with and make sure that they have everything that they need and getting blood pressure cuffs to people, thermometers to people, oximeters to people, and things like that.

Kathie Powell, MSHA, MA:

We're doing a lot of reaching out and we've repurposed a lot of our staff. So we actually took some of our front office staff and I think we have four previous front office staff who are now a help desk for our patients and they're reaching out for patients, especially elderly patients, to make sure that they're signed up for our portal and that they know how to use, or someone in their household knows how to use, the video feature in that so that when they need an appointment we can easily set up a video appointment with them. And that helps us with the Medicare billing.

Kathie Powell, MSHA, MA:

We were lucky in California that shortly after COVID appeared that the state did start allowing us to bill for video and telephone visits. So that has helped us tremendously financially. And we did receive a PPP forgivable loan, hopefully it will be forgivable, from the Small Business Administration. So that has helped us along with our grants from HRSA, which are amazing and wonderful, and we are doing several external parking lot clinics that we do the testing for COVID outside, we have a respiratory clinic as well outside, and then we do vaccines. We have vaccine clinics for under two year old children, who that's the group that we've started with, and doing some of the well child check measures by phone before those visits and then doing some actually in the car with the kids.

Kathie Powell, MSHA, MA:

And, what else have we done in the parking lot? Well, we set up a procedure clinic, but I think part of that is in the parking lot and part of that is actually inside the clinic. That hasn't started yet. That starts next week in a wound care clinic as well. We just keep trying to figure out how we can provide all of our patients with what they need in a financially sustainable way. And it's working so far, fingers crossed, and the patients are really appreciative about how we're reaching out to them. So, kind of an overview.

Ron Yee, MD, MBA, FAAFP:

Thank you.

Kathie Powell, MSHA, MA:

Thank you.

Ron Yee, MD, MBA, FAAFP:

Thanks Kathie. We'll let Dr. English go and then we'll come back to Alan Mitchell from Health Efficient. Dr. English, could you share some thoughts with us and then we'll come back to Alan Mitchell and he has some slides too.

Ramona English, DMD:

Of course. Thank you so much for having me on the call and I really appreciate the interest. I'm actually humbled by the interest. And I also want to thank Kathy for always encouraging me to make patient centered decisions. Going back to March 16th, which seems like a century ago, we closed one of our sites and limited dental services to emergent and urgent care only. We had to quickly adapt our training protocols and eliminated aerosol producing procedures.

Ramona English, DMD:

Initially we went from seeing 120 patients a day to only eight, and the only good thing about that was with only one dentist seeing patients, our PPE needs were greatly reduced. With more than 100 patients becoming overdue for care daily, we started to worry about future backlog and maintaining patient quality outcomes. We also started to worry about cavities growing all over the place and children needing to go to the OR to receive care under general anesthesia.

Ramona English, DMD:

Quickly, we identified a teledentistry platform and started testing different types of visits. We started with emergency screenings when our front office staff needed help triaging. Later, we decided to also engage families of children zero to six that were at high or moderate risk. We already had a successful clinic care model for these patients and it seemed that we could provide almost the same care via video. Teledentistry would allow us to stay engaged with patients that otherwise would've just been canceled.

Ramona English, DMD:

We decided to provide video live transmission visits between the dentist, the assistant, the patient and the parent. We had our staff set up with laptops, call and text capabilities and access to patient records, and then when we surveyed patient preferences, it became clear that patients prefer to click on a link versus having to download an app or a plugin. So, we created a process map that we still continue to refine. In the beginning we were scheduling from one day to the next and now we're scheduling one week out. We also need to do appointment confirmations and same day and reminders. Every time we communicate with a patient, we tell them how the visit will go and how to best prepare for it.

Ramona English, DMD:

We currently scheduled this for an hour each. The dentist is the one that initiates the visits via a link that's texted to the patient and then the assistant calls the patient to offer them support with logging in and then once all our online, the visit begins with introductions. We identify the patient and the parent and obtain verbal consent. We explain the circumstances, preventing the office visits and what services are offered at this time in clinic. We also ask COVID-19 screening questions and offer referrals if needed. We perform either medical history review, ask about chief complaint.

Ramona English, DMD:

When it comes to the dental history is where we use motivational interviewing for enhanced patient engagement and self-management. We spend a lot of time on this section asking open ended questions, using active listening, affirmations, reflection, summarizations. This is how we learn about the patient's home care diet, fluoride exposure, trauma prevention, daily routines and their hopes for their oral health. When we look at the levels of evidence for cavity prevention, all interventions except sealants can be self-administered. Patient engagement and self-management has shown to be more important than we've seen in the cleaning in the office twice a year.

Ramona English, DMD:

Next, the dentist performs a visual exam via live video and reviews intraoral photos submitted by the parent along with current radiograph. Based on the information gathered so far, the dentist determines the patient's risk level, makes the diagnosis and creates a treatment plan. The treatment plan includes prescribing fluoride if needed along with a behavior plan consisting of self-management goals. We start by reviewing the patient's previous goals and keep the same goal with different strategies or choose a new goal. Goals are specific and we identify different seats and barriers. We also assess the patient's competence level with achieving their goal and plan for the next visit. That can be either a follow-up at a later date or just the next recall in three, four, or six months.

Ramona English, DMD:

With patient's permission, we also provide anticipatory guidance and nutritional counseling based on their dental history. Next, we have the parent and the patient demonstrate tooth brushing and flossing. This allows us to see and give feedback on the type of brush, toothpaste, how much toothpaste is used and the brushing technique. Next, we ask the patient to open the self-care package they received from us in the mail. We go over all the contents, toothbrush, toothpaste, floss, disposable mouth mirror, gloves, gauze, fluoride varnish with brush and sticker. Sticker is very important. We ask the parent if they're comfortable with applying fluoride varnish on their child's teeth, if they are the dentist coaches them on how to apply it.

Ramona English, DMD:

Home care instructions are given. The assistant schedules the next appointment for the patient after which the patient needs the visit. There is a bit of follow-up work to be done, since up to this point the visit was alive with both dentists and assistant directly participating. For efficiency, we divided the task between the assistant and the dentist. The assistants via text patient education materials prescribed by the dentist during the call, calls in prescriptions given by the dentist and sends the patient satisfaction survey via texts. The dentist records the visit timestamp, the risk assessment form, clinical notes, codes, signs and logs the chart.

Ramona English, DMD:

Striving to improve the patient experience, we learned some lessons along the way. We learned that we needed to communicate with patients about this new types of visit. So, we included information in the patient newsletter and on our website. We had a demonstration for the front office staff after experiencing it firsthand. They were more able to explain the visit to the patient and its benefits when scheduling. Then we created a patient visit preparation list to let them know how the visit will go, how to prepare for a successful visit and what to review and submit in advance. We learned that we needed good intraoral photos taken by parents on their phones. So, we created video with examples and instructions for parents on how to do this.

Ramona English, DMD:

We started sending out patient care packages. We had to figure out how far in advance they would have to be mailed. They would be present during the video visits and what those packages were going to contain. We started sending a video with instructions for the parent on how to apply the fluoride varnish. We developed new patient education materials with lots of photos that could easily be texted to the parents and we also started assessing patients experience by asking, on a scale of 1 to 10, 10

being the highest, how likely are you to recommend this type of visit to family and friends? So far, we are at 9.7 out of 91 surveys. Staff satisfaction is also high.

Ramona English, DMD:

In terms of data, the no show rate this month for video visits has been 3%. A lot less than for in clinic visits, which before COVID was at 15% for in clinic visits and during COVID, they have been studied 37% no show for in clinic visits. We have provided so far, 236 video visits, 32 of them being in March. We started with one dentist and now we have three dentists providing tele dental visits. Another group that we wanted to engage were children zero to six that had caries and those caries were at the risk of progressing and causing them to need care in the OR. These children were in need of treatments with silver diamine fluoride. Silver diamine fluoride is a topical medication that when applied to caries or cavities, it stops their progression.

Ramona English, DMD:

Due to the quick and easy nature of the silver diamine fluoride application protocols. We started wondering if we could apply it in the patient's car in a drive through type of setup. We consulted with our medical side on how they were conducting the immunization drive through and came up with a similar process. We scheduled the patient, set up a tent in front of the building. Directed the patients there and a dentist and an assistant provider that SDF treatment to the patient in the backseat of their car. Everything went very smooth and we were able to adopt the change right away. There was no need to refine and test again. We saw 31 patients this way and have an additional day planned in a couple of weeks.

Ramona English, DMD:

Dental cavities are a chronic disease managed by risk assessment, medicine, and this case, fluoride and lifestyle changes. Acute episodes are treated surgically. Only 65% of our patients, 0 to 16 seen in clinic in 2019 have returned for a risk based recall visit in a timely manner and only 35% of patients seen for a well child check in medical had a dental visit before age one, 86% of medical beneficiaries have a smartphone, same as the general population. So, then my question is, can we manage the chronic disease via tele dentistry while increasing access to hands-on and acute care in the clinic and can tele dentistry play a role in reopening. And my hope is that our program demonstrates meaningful ways of engaging patients in a new way, while maintaining the value of care and patient outcomes. Thank you.

Ron Yee, MD, MBA, FAAFP:

Thank you. Thanks Kathie and Dr. English. Wow. I'm going to have to go back and look at the transcript on that. You had so many great points, so thank you so much for that. We're going to move Alan Mitchell, Executive Director of HealthEfficient. As I mentioned before, a New York based Health Center Controlled Network. Alan.

Alan Mitchell:

Thank you so much Ron, and good afternoon everybody. It's such an honor and a privilege to meet with you all today and talk through some of the work that we've been doing at HealthEfficient, our Health Center Controlled Network along with our partners today. I do have some slides today if I could ask the moderator to bring those slides up on the screen.

Ron Yee, MD, MBA, FAAFP:

So, Alan, I know some things are delayed on some of the systems, so we'll try to do that, if that doesn't work, you can walk through them and then the group can download them afterwards, so if they come up, go ahead, if not we can download them afterwards in the resource button on the bottom left. So, go ahead.

Alan Mitchell:

Okay, great. Excellent. Thank you, Ron. And it looks like that was just a pause we needed to get my slides up on the screen. Let's go to the next slide please. I'm here today to talk specifically about the work that HealthEfficient has been doing. But many of the things that you'll hear me describe are things that Health Center Controlled Networks all around the country are doing. And if I could ask the moderator to advance to the second slide.

Alan Mitchell:

HealthEfficient is a not-for-profit mission driven organization based in New York state, but we operate in seven states and Washington DC. Mostly up and down the East Coast. Although, we extend all the way over to Louisiana. We are HRSA designated as one of 49 Health Center Controlled Networks nationwide. So, as I said, there are 48 other organizations out there working just as hard as we are to support their member health centers. I should mention for those of you on the call who are not familiar with Health Center Controlled Networks. That Health Center Controlled Networks are membership organizations and their members are community health centers nationwide. We at HealthEfficient, have a very close partnership with two PCAs. Those are the District of Columbia Primary Care Association and the Mid-Atlantic Association of Community Health Centers that covers both Maryland and Delaware.

Alan Mitchell:

And I would like to take a moment to extend a special welcome and thank you to the members of HealthEfficient nationwide who are doing so much work on the front lines of addressing coronavirus and COVID-19. As well as to all of you at all the health centers nationwide who are working so hard on the front lines to address this disease.

Alan Mitchell:

I did want to mention that Health Center Controlled Networks are not generally by definition limited geographically. We have and can extend across several states or regions to support the health centers that may have something in common or may have other affinities among their populations or the technologies that they're using or their approaches to care. And so, although you may be in a state on the West Coast for example. There are Health Center Controlled Networks out there in other parts of the country or on the West Coast that can help you and do the type of work that we're discussing today.

Alan Mitchell:

I also would like to mention that in addition to operating our Health Center Controlled Network project, we also are a grantee from HRSA's bureau of maternal and child health to operate a network for oral health integration. A five-year project to integrate oral health into primary care, specifically focused on pediatric patients. There are three such networks for oral health nationwide and so Dr. English's comments just a moment ago are extremely relevant to the work that we're trying to do under the offices of that project as well.

Alan Mitchell:

The mission that you see on the screen is our mission, but I think it's a mission that extends broadly for many, if not all of the other Health Center Controlled Networks out there. We aim to help the health centers improve their clinical and operational performance through the use of health information technology, but not only through the use of health information technology as HCCN's. We pride ourselves on our ability to deploy collaborative efforts to put the health centers in touch with their peers at other health centers. So that we can all move forward together on whatever it is that we're trying to accomplish and the opportunities for that collaboration have never been more timely than at this moment in which we all meet today and that's what I'm going to talk about for the remainder of my presentation.

Alan Mitchell:

I do also want to state that for our members who are members of HealthEfficient and our HCCN, we do not charge our members for the services. Everything that you are going to hear about today is thanks to the funding that HRSA provides to the Health Center Controlled Network program. It would not be possible for us to do it at that scale without the funding from HRSA. Thank you to our partners and colleagues at HRSA for their support of the HCCN movement.

Alan Mitchell:

I'd want to also take a moment in more detail to further acknowledge the work of DCPCA and MACHC by partnering so closely with the PCA's we're able to double and even triple the impact of the work that we're doing. Tamara Smith, Karen Williams and Shirley Sutton from DCPCA and MACHC have all been terrific partners through the course of our HCCN and project and have inspired me personally to do the very best that we can for our shared members. If I could ask the moderator to go to the next slide please.

Alan Mitchell:

While the slide catches up, let me take a moment to talk about a comparison between the challenges that we all face associated with addressing COVID-19, specifically at the health centers. And the HRSA's goals for the Health Center Controlled Network program. In the context of COVID-19, health centers are facing these challenges that are on the screen on your left, and these challenges are all too familiar to so many of you on the call today. You've got sites that have closed, your patients are at home, either stuck at home or unwilling to come out to the health centers. You have your own clinicians who may be quarantined or as we heard a moment ago, working from home. The risk of provider burnout and provider burden has perhaps never been greater than now, in recent times.

Alan Mitchell:

As we know, almost everyone on this call who provides healthcare services had to adopt telehealth almost overnight. I heard the date of March 16th earlier from Dr. English, and I think that that date will be burned into our minds for many, many years to come. As that was the week that all of this work suddenly took on incredible urgency and we all worked together to adopt telehealth and address our new realities. There's a need to attract COVID cases the tests and address risk among our patient population. And many other challenges, both regulatory and clinical, and technology based that we all face. But thankfully the Health Center Controlled Network program exists and had already articulated goals for the HCCNs at the start of this cycle of funding, which began in the middle of last year. And thankfully the goals that HRSA established for the HCCNs align almost perfectly with the challenges that

we face today. The language on the right-hand side of your screen comes directly from HRSA's goals for the HCCNs. We are to collectively, all 49 of us, address patient engagement with their data and their care plans, patient access to care. And there you can read telehealth. Addressing provider burden, protecting data, participating in health information exchange across a geographic area or a health system and integrating data from disparate sources.

Alan Mitchell:

I think back to when I first read the goals that had been established for HRSA and how those goals explicitly called out the need to integrate clinical and nonclinical data sources. And what don't you know, at this moment that that is extremely crucial for us in our COVID-19 response. Data analytics, addressing the social determinants of health and then each HCCN is then able to select a particular issue that they wanted to focus on, which for HealthEfficient and the Quality Network, our network is called the Quality Health Center Controlled Network. We selected opioid use disorder. And we see challenges associated with that these days as well.

Alan Mitchell:

If I could ask the moderator to proceed to the next slide and I'll speak specifically about how HealthEfficient and the Quality Network with our partners at DCPC and MACHC functioning as one team have addressed these challenges. As we wait for the next slide, I'll continue with my comments. The first thing that we did very early in March as we understood that COVID-19 was going to be widespread and confront our Health Centers with numerous complex long-term issues is we developed a strategy and in certain focus areas to address. Those areas are on your screen. These areas are the items that we knew were going to be a strategic importance to us and to our Health Center in those opening days. And they continued to be the cornerstone of our strategy addressing COVID-19. So first off, we knew that we needed to help everybody jumpstart their telehealth programs. And we could do that in a number of different ways, including helping them to select either an initial vendor or now we're starting to see some movement towards selecting a secondary vendor.

Alan Mitchell:

We were also able to liaison with the vendors, whether those are the EHR vendors, the population health analytics systems vendors or the telehealth vendors to aggregate the voices of our member health centers and amplify them as much as possible to the vendors. We knew early on that some of the EHR vendors were not at all planning to have to onboard everyone all at once to telehealth. And we worked with them very closely, including nights and weekends, to bring in additional features into their platforms that are FQHCs and other health centers out there were demanding and requiring for the benefit of their patients. We also provided not just the technology guidance and not just the vendor work, but regulatory guidance as well. Working hand-in-hand with the PCAs. And I can't emphasize enough how important it is for the PCAs and the HCCNs to work together during times like this that are truly an all hands on deck effort.

Alan Mitchell:

Additionally, we wanted to focus our efforts on providing data analytics. Historically, we've done a great deal of work with our members on EHR data and population health analytics for quality improvement and operational efficiency. In this case, we now know that case tracking and risk stratified care management become even more important. Additionally, for the first time at HealthEfficient, we started

incorporating public health data, publicly available datasets into the work that we're doing. And I'm going to demonstrate some of that in just a moment. Naturally, we also wanted to work.

Alan Mitchell:

Additionally, we have our support for health information technology, generally. And perhaps the most important thing we can do during this time is to establish collaboration and peer sharing among our members, CEOs, CMOs, CIOs and line staff. And we did that through numerous webinars, as well as our first ever in-person virtual conference. Next slide, please.

Alan Mitchell:

I mentioned, and I do need a visual for this one. I mentioned that we incorporated public health datasets into our work. And we've published these visualizations that we've created to a public website operated by Tableau, the data analytics company. We created four dashboards initially and I'll ask the presenter to ... they're blank as they're in the slides when you download the slides, I'll ask the presenter to go on to the next slide. I'm going to focus on one of these visualizations that we created. If you look at that third one in, and hopefully it'll show up in a moment, zoomed in. What we see here is a map of the United States showing case count by County, overlaid with a dot representing every Federally Qualified Health Center delivery site in the country. And what we're able to do with this, this is something that we created about a month ago at HealthEfficient. And it's been publicly available since then.

Alan Mitchell:

You can zoom in, you can select the County, and you can zoom into the County level and see the exact case count in that County. And you can see the FQHC delivery site marked on the map. And if you hover over any dot, you will see the exact name of that delivery site. Shown on the map here is Finger Lakes Community Health, one of our members in New York state. I'd encourage everybody to check this out when you have some time. It's an indicator of what we can do when we have access to timely and comprehensive data. If I could ask the moderator to go on to the next slide. I'm going to show what we've been doing at the EHR and patient level.

Alan Mitchell:

We've also been working to extract data from our members EHRs to support them in responding to COVID-19, including with risk stratified care management. And I say risk stratified care management rather than risk stratification, because risk stratification is an exercise in data, but care management is a clinical exercise. And by bringing together the best data, and comprehensive data and accurate data, you can more effectively manage your patient. What you see on the screen here is hard to read, but what it represents is our COVID-19 risk stratification dashboard.

Alan Mitchell:

Those lines of patients in the middle. That's imaginary data, but it reflects the risk stratification modeling that we've done. You can click on any patient and see their risk factor based on CDC guidance. And you can see how many patients you have in each of the different risk levels. In this model, you see that many, many patients are at the primary risk level. But increasing in risk, the numbers go down. And as you have limited resources to concentrate on care management, you can target those patients, specifically. Keeping in mind that these patients are your most vulnerable patients and are in most need of care management and care coordination activities to reduce their risk. Next slide, please.

Alan Mitchell:

There are many challenges and opportunities that the Health Centers and the HCCNs are facing. From the HCCN perspective, we had to make rapid investment in our resources that were unbudgeted to address the need. We're very hopeful that as the various packages come through into HRSA, and to the Health Center Program, that investment can also be made in the HCCNs and the PCAs to continue this type of work that I've been talking about today. We've had to keep up with a fast evolving regulatory environment and the new normal is unknown. The opportunities for the HCCN are to continue this work and addressing the Health Centers COVID-19 needs. Using both public and clinical data and helping them to make the best use of technology. As I wrap up here, what I wanted to share with everyone is a perspective about how collectively we're all going to get through this.

Alan Mitchell:

We all have to respond to this new normal. Working from home, having perhaps second and third waves of an epidemic and so on. Yet, the new normal is not something that is going to happen to us. It is something that we will define together. Next slide, please. And as we do that the Health Center Controlled Networks are here to support the health centers and indeed every stakeholder on this call and working together to define and address that new normal. Whether it's addressing provider burden, new forms of lab testing, addressing population health, considering workforce realignment as we better understand the consequences of immunity or non-immunity, and addressing unemployment and homelessness out in the general population that are going to result in increased demand for our health centers. Thank you. I had limited time today, but I wanted to share with you as much as I could about the work that we're doing.

Alan Mitchell:

I'm looking forward and I know all HCCNs are looking forward to working with you in partnership through this time. Thank you.

Ron Yee, MD, MBA, FAAFP:

Thank you, Alan. And this is so critical. It's amazing what the networks are doing, how you all are able to drill down on a lot of this information and actually get down to care management. We appreciate that. We have a couple of minutes left. Ellen, do you have any questions that have bubbled to the surface that we might be able to address in our limited time that we have left? Maybe one to two?

Ellen Robinson, MHS, PMP:

Yeah. I think a lot of people are asking great questions about how Dr. English and the folks at Petaluma are doing telehealth dentistry with regard to providers wearing PPE in the parking lot, what telehealth platform they're using and what codes are being used. Throwing them all into one question.

Ron Yee, MD, MBA, FAAFP:

There you go, Dr. English. If you could.

Ramona English, DMD:

Yes, thank you. Yes, so the PPE, we wear a respirator mask, face shield, we have full gown, head cover, shield cover. So, that's been our PPE level that we've been maintaining all this time. It's the same in the parking lot. I mean of course, we have gloves and all the previous stuff too. And I think one question was

about visit documentation, right? I mean we always document the work that's being done. It's not with a focus on billing and revenue, increasing revenue. So, we just use the codes that describes the work, like the exams, the risk assessment, motivational interviewing and things like that. The clinical notes are very comprehensive. We did set up templates that document really well, everything that's being done and provided, and they are in compliance with the current situation. And what was the third part of the question? Sorry.

Ellen Robinson, MHS, PMP:

The telehealth platform that you all are using.

Ramona English, DMD:

Yeah. We are using doxy.me, which is very user friendly. It creates a link for the visit and then the patients click on it. And then where you can have a group call. And it's allowing for the assistant and me and the patient to be on the call. We can share files also, but I know there are other great ones out there and some of them actually integrate with an EDR. I encourage folks to see what's available in case they find something that integrates with their EDR. Doxy.me doesn't integrate with our EDR.

Ron Yee, MD, MBA, FAAFP:

Great. Thank you, Dr. English. And thank you, Ellen. Again, I want to thank everyone for joining us. And especially I want to thank our federal partners, Dr. Koonin from CDC, Jim Macrae with BPHC, and NACHC President and CEO Tom Van Coverden. And a special thank you for the great insights from the front lines from Alan Mitchell, Executive Director at HealthEfficient, and CEO Kathy Powell, and Chief Dental Officer, Ramona English at Petaluma Health Center.

Ron Yee, MD, MBA, FAAFP:

Next week we will be back, Thursday May 7th, at 1:00 PM Eastern time. This is a topic that we've had many requests on and was mentioned today is COVID-19, testing. So, we're going to take a high level look at that and drill down. Thank you for joining us today. Please stay safe and healthy. And again, the transcript will be up next week as well as the recording. We're with you to support you in the health center COVID-19 challenge. Take care, everyone. We'll talk next week.