

Leading in the Crisis: Flattening the COVID-19 Curve
Strategies for Testing in a Public Health Crisis Webinar

Thursday, May 7, 2020

1-2PM ET

Speakers:

- Alex M. Azar II, Secretary, U.S. Dept. of Health and Human Services
- Thomas J. Engels, Administrator, Health Resources and Services Administration
- Andrew Hamilton, RN, BSN, MS, Chief Informatics Officer, AllianceChicago
- Mary Hayes Finch, MBA, President and Chief Executive Officer, President and Chief Executive Officer, Alabama Primary Health Care Association
- Lisa M. Koonin, DrPH, MN, MPH, Senior Advisor, Centers for Disease Control and Prevention
- Brandi Limbago, PhD, Associate Director for Laboratory Science, National Center for Immunization and Respiratory Disease, Centers for Disease Control and Prevention
- Jim Macrae, MA, MPP, Associate Administrator, Bureau of Primary Health Care, Health Resources and Services Administration
- Fred D. Rachman, MD, Chief Executive Officer, AllianceChicago
- Robert Record, MD, Chief Executive Officer, Christ Health Center
- Ron Yee, MD, MBA, FAAFP, Chief Medical Officer, National Association of Community Health Centers
- Tom Van Coverden, President and CEO, 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. Today, our focus is going to be Strategies for Testing in a Public Health Crisis. This national partner update is provided today to help align efforts with the Department of Health and Human Services, the Health Resources and Services Administration, the Bureau of Primary Healthcare, CDC, Primary Care Associations, Health Center Controlled Networks and health centers across the nation in our COVID-19 response. We are so honored today to have HHS Secretary Alex Azar and HRSA Administrator Tom Engels joining us. You'll hear from our top federal healthcare leaders, including state, network and health center representatives regarding COVID-19 testing, from funds for this work to practical frontline innovations in health centers today. In seeking to be responsive to the needs we're hearing from the health center field week by week, we are here to support the health center movement.

Just a few housekeeping items to start with. Some presenter slides will be used during the call today. The slides, recording and transcript will be posted on the NACHC website. Slides will also give you instructions on how to ask questions, as we are using a different format today, the WebEx platform. So please use the chat button on the bottom of the WebEx window to open the chat box to enter any questions you might have. And at the end of the call, we'll group the questions together around similar topics to make this more efficient for all of us. Tom Van Coverden, President and CEO of NACHC, will introduce our honored guests today, Secretary of Health and Human Services, Alex Azar, and HRSA Administrator Tom Engels. Following Secretary Azar and Administrator Engels will be Jim Macrae,



Associate Administrator, HRSA, Bureau of Primary Health Care. Then, doctors Lisa Koonin and Brandi Limbago from the Centers for Disease Control and Prevention will share some comments.

Following our federal partners, we'll hear from Fred Rachman, CEO, and Andrew Hamilton, CIO and Deputy Director, from AllianceChicago, a Health Center Controlled Network. Next, we'll have Mary Hayes Finch, CEO of the Alabama Primary Health Care Association. And finally, we'll, hear about testing innovations from the front lines of health center community engagement. This includes Dr. Robert Record, CEO, Christ Health Center, Birmingham, Alabama, with his CMO, Dr. Amelia Haueter and CFO Elizabeth Fourie, who will share some comments and ideas about testing best practices. So, Tom, I'll turn it over to you to introduce our honored guests.

Tom Van Coverden:

Thank you, very much, and welcome Secretary Azar. All of our Community Health Centers and Networks and state Primary Care Associations, we're here to say thank you for being with us. You are an incredible leader, and we are partners with you and a valuable teammate you bring to the table. I'm not just saying that. I've been with NACHC now for 45 years, and I've been through a number of Secretaries and friends of yours like Mike Levitt and Tommy Thompson, who I still consider very deep friends and good friends. And, again, what an incredible job you're doing, especially in this very trying time. I refer to your earlier speech when I started. Wouldn't it be nice if we had partners who were leading the way in value-based care, using all electronic health records and excel at coordinating it and integrating different levels of care? And you said you do. I do. It's all of you. The American Community Health Centers.

And so, again, it's that spirit of leadership that I think has led us and inspired us. And I want to reassure you from all of us that we're here to help you very much and help our nation, help our communities in this COVID-19 battle, certainly to be testing in many, not only our current patients, but to see what we can do working with you and the Department as well as state and local governments. And so, to coordinate the tracing with those state and local efforts and then to treat with vaccines. So, as Mr. Secretary, again, I could not be, and I know I'm speaking for all of us, more appreciative. A lot of centers struggling financially, but you've done a lot, the entire department, to try and get additional resources. And those have gotten into the health centers, and it's deeply, deeply appreciated. And we'll be attempting to fight even for more as we want to do more to help you and the Department do that.

HRSA Administrator Tom Engels is a great friend, worked with Secretary Thompson in Wisconsin, and he has been great at pulling the whole HRSA team together. And, of course, Jim Macrae, you and the Bureau of Primary Health Care and our friends at the Centers for Disease Control. Mr. Secretary, you have our full support, and we thank you for making this time available.

Secretary Alex M. Azar II:

Thank you for those kind words for HHS and for HRSA and the team here. And good afternoon to everybody. And thanks to NACHC for inviting me to participate in today's call. As Tom mentioned, one of the very first large gatherings that I addressed as Secretary was NACHC's policy meeting in Washington in March of 2018. Actually, I think it was across the river in Maryland technically. So, I'm glad to join another NACHC forum, albeit remotely and in these trying times. I'm also happy to be connecting with health center leaders for the third time during this pandemic, joined by our fantastic HRSA Administrator Tom Engels and by the great Jim Macrae, our Associate Administrator and the head of the HRSA's Bureau of Primary Health Care. I know that they have been dedicated to staying in close touch with you all and our health centers during this crisis.



I want to first thank all of you for what you and your teams have done to ensure access to primary health care services for our nation's most vulnerable populations during this public health emergency. We at HHS and all Americans are truly inspired by what safety net providers are doing in America's small towns, big cities and rural and frontier areas. The COVID crisis, I can tell you, has provided even further impetus to educate policymakers and leaders about the incredible work that America's Community Health Centers perform and just what a backbone of our healthcare system you are. Over the past month, I've had the chance to announce to many of you more than \$1.4 billion in supplemental health center awards to battle COVID-19. Last week, we announced new allocations of money, especially for rural health centers through the CARES Act Provider Relief Fund.

Today, through HRSA, we are now awarding an additional \$583 million to 1,385 health centers. These new grants signify the Trump administration's ongoing commitment to health centers as well as a recognition of that essential role that you are playing in the public health response. HRSA-funded health centers can use these new funds to expand testing and testing related activities, including PPE purchases, training, outreach, procurement and administration of tests, lab services, and expansion of walk-up or drive-up testing. As Tom will explain in more detail, we've seen health centers begin playing a vital role in expanding testing, especially for vulnerable communities, and you should be proud of that work. I want to note that because health centers can help notify contacts of patients who test positive, we also hope you will work closely with state and local public health departments on their testing and contact tracing activities as states begin to reopen.

Finally, I want to praise the work that HRSA has done to fulfill president Trump's promise to cover COVID-19 testing and treatment for uninsured patients. HRSA launched the portal for providers to file for these reimbursements last week, and more information on how to file is available at hrsa.gov/coviduninsuredclaim. These past few months have been the most challenging times ever faced by our nation's healthcare system and our healthcare providers. We know the challenges have been even greater for safety net providers. Heroic action on the front lines in vulnerable communities is key to defeating COVID-19. I ask you to pass along the deepest thanks from me, from all of HHS and from president Trump to everybody staffing your health centers and helping to keep them running in these difficult times. Your work in your communities has saved and will continue to save many, many lives, and I thank you for it. So, thank you, again, for your work so far. And I'll now turn it over to Administrator Tom Engels for a HRSA update.

Administrator Thomas J. Engels:

Thanks so much, Secretary, and thank you for joining us. I know you have a very busy schedule, and we all appreciate you taking a few minutes to talk with us today. And thank you to Tom Van Coverden and to NACHC for today's call. Hello, everyone. My name is Tom Engels, and I'm the Administrator of the Health Resources and Services Administration. Two weeks ago, HRSA announced \$1.32 billion in operational support for health centers responding to COVID-19. While substantial, HRSA recognized that health centers were being acutely impacted by COVID-19 and a greater level of support would be needed. And today, the US Department of Health and Human Services through the Health Resources and Services Administration awarded nearly \$583 million to 1,385 HRSA-funded health centers in all 50 states, the District of Columbia and eight US territories to expand COVID-19 testing. That's \$2 billion in COVID-19 support for health centers over the past six weeks.



I want to thank Jim Macrae and the staff in HRSA's Bureau of Primary Health Care and the Office of Federal Assistance Management for their rapid response efforts. Today's funding for health centers is part of the Paycheck Protection Program and Health Care Enhancement Act signed into law by President Trump on Friday, April 24th. The legislation provides funding for small businesses and individuals financially impacted by COVID-19, additional funding for hospitals and healthcare providers and increased testing capabilities to help track the spread and impact of coronavirus. Health centers can put these resources to immediate use to expand COVID-19 testing and related activities, including the purchasing of tests, PPE, expanding walk-up and drive-up testing capabilities and laboratory services. Health centers are doing a great job testing for COVID-19. Nearly 88% of HRSA-funded health centers are testing patients for COVID-19, with over 65% offering walk-up or drive-up testing. Last week, health centers provided more than 100,000 COVID-19 tests, and these additional funds will help to sustain and expand these testing efforts.

The Paycheck Protection Program and the Health Care Enhancement Act also provided funding to support and expand COVID-19 testing efforts for federally qualified health center look-alike organizations. HRSA is working to quickly develop a spend plan to expedite distribution of this critical funding. Health centers are the first line of defense, testing for coronavirus and delivering high quality primary care to our nation's most vulnerable populations. In the fight against coronavirus, we must marshal all of our resources to keep Americans healthy and care for those who become ill. Thank you for your continued commitment to providing quality primary health care services to the nation's most underserved populations. HRSA stands arm in arm with you and will continue to support you in any way that we can. Thank you very much.

Ron Yee, MD, MBA, FAAFP:

Thank you so much, Secretary Azar and Administrator Engels and Tom Van Coverden. Appreciate the efforts in the alignment of our work. Next we'll hear from Jim Macrae from the Bureau of Primary Health Care. Jim?

Jim Macrae, MA, MPP:

Great. Thanks, Ron. And good afternoon and, of course, good morning to those out in the Midwest and on the West Coast. We're so happy to have the invitation, of course, from NACHC. Also, very pleased to have the Secretary and Tom Engels on the call as well as our colleagues from CDC as well as our Health Center Controlled Networks, all the Health Center Primary Care Association folks, the health centers. It really is a great day in terms of being able to share some really good news, which you heard from the Secretary. As both Tom and the Secretary mentioned, we were very, very happy to get out our resources, so hopefully everybody has started to see in their notice of grant award that those resources are coming through. This pot of money, the \$583 million, is targeted to 1,385 health centers across the country.

In terms of what health centers can do with this, it's, of course, to maintain, but we hope to also significantly increase the capacity of health centers to be able to do testing. As Tom mentioned, we did over 100,000 tests this last week in our nation's health centers. And of those tests, about 59% were for racial and ethnic minorities, a particularly vulnerable population that we serve through our Health Center Program. On the other side, unfortunately, of those 100,000 tests, almost 20,000 of our patients tested positive, and about 65% were racial and ethnic minorities. So, the work that you're doing with testing is critically important. You can also use these resources to help you with purchasing testing

supplies, equipment, personal protective equipment, as well as to help support your lab capacity. And we did get some better news in terms of the turnaround time on your labs' results. About 19% of health centers were able to receive their lab results in a day or less. About 16% able to receive their lab results in a day or less. About 64% were able to see their lab results within two to three days. About 13% were able to see their COVID-19 test results within four to five days, and about 4%, it took about five days or more to be able to get those test results. So, we hope to be able to continue to see those numbers improve. We're seeing that it looks, week to week, that it's getting better and better. We also were very pleased, as Tom mentioned, just as health centers that are doing drive-up and walk-up testing, with well over 65% of health centers being able to do that. That really is fantastic.

A couple of key things, though, that we really are asking the health centers to focus on is the whole area of community and patient education, as well as outreach. We want to make sure that folks are aware of the resources that are available in health centers now, but we also want to make sure that they're coming in, if they do have symptoms, to get tested, because that's so critically important. The other piece, of course, that we want to add is if people do test positive, health centers do... And we're asking them to notify the contacts of those infected patients of their exposure to COVID-19. The Secretary mentioned that. Of course, we want that to be consistent with communicable disease reporting and privacy laws, but we do see a key role for health centers, to be able to talk about the potential spread of COVID-19.

Equally critical, though, is as states develop their plans to reopen, testing is going to become even more important. And so, we've asked state primary care associations all across the country to reach out to their states as they develop their testing and reopening plans. We really have asked them to share the importance of the testing in vulnerable populations, but also the capacity, and I would say the tenacity and the willingness of health centers to do testing all across the country, and in their particular states and in their communities.

And so, I just want to end with four key points in terms of testing. Please continue to do your efforts about outreach. Critically important, especially for vulnerable populations. We know how important and how disproportionately impacted they are. Please test, test, test. We are in a sprint, but this is also a marathon, so these resources are available for up to 12 months. And so, as we begin to pivot towards antibody testing, we want to make sure that health centers are able, capable and have the resources to be able to do that. We do want you to take advantage of the program that the Secretary mentioned, the Testing Reimbursement Program. Health centers, that is a resource that we are asking you... In fact, it's one of the requirements that you use that program as much as possible, to make sure that uninsured patients have the tests that they need, as well as care and treatment.

And then finally, just to continue to recognize your critical role of reopening your health centers that testing can play. Testing both for your staff and for your patients gives everybody the security that they can go out into their communities, but also that they can practice in our community health centers across the country. So, as Tom Engel said, and as the Secretary said, thank you again for all that you're doing. I think the resources and really the commitment that you're seeing really is a testament to the work that you all are doing, and you are all on the front lines for those who are most vulnerable and making a tremendous difference. So back to you, Ron, and thank you so much for the opportunity to participate today.



Ron Yee, MD, MBA, FAAFP:

Thank you, Jim. Thank you so much. Our CDC partners and experts, Doctors Lisa Koonin and Brandi Limbago, will share some important information from the CDC. Dr. Koonin?

Lisa M. Koonin, DrPH, MN, MPH:

Thank you, Ron. It's a pleasure, again, to be here with you today. We want to continue to express our gratitude as all of you in the community health centers, and the work that you do every day to save lives and protect us during this COVID outbreak. Because the theme of the meeting is about testing, I'm very pleased to introduce my colleague, Brandi Limbago. Dr. Limbago is serving as the co-lead of CDC's Laboratory Task Force during this response. Dr. Limbago?

Brandi Limbago, PhD:

Hello, and thank you Lisa for the introduction. I'm going to be speaking to you I think from a slightly different place than our previous speakers, telling you about sort of more of the specifics and the nitty gritty of testing, but I hope it will also be useful to all of you.

As you know, CDC testing guidance is available, and has also recently been updated. It continues to include prioritization of hospitalized patients who have symptoms, as well as healthcare workers, people in congregate living settings, and first responders who display symptoms, as well as residents of long term care facility or other congregate living sites. Excuse me... who have symptoms. So, the bottom line, people with symptoms are the highest priority, but then also patients without symptoms who are prioritized by health departments or physicians for any reason. And so, the guidance is really written here to be as flexible and broad as needed, to be able to address whatever testing priorities arise in your community setting, so I hope that will be useful for you.

I also want to speak to you about the kinds of tests that are available. So, generally speaking, we have two kinds of COVID testing approaches. The first is diagnostic. Primarily this is molecular testing. This is what we use to diagnose active infections. So, this is usually through collection of an upper respiratory sample. It could also be a lower respiratory sample. Those are much less common. And one of the things that has been done recently to make this more accessible and approachable is to change the preference from the collection of an NP swab... which is a sort of difficult to collect sample, that requires specific use of PPE just for the sample collection. It is sort of unpleasant for patients... to also allow collection of alternate sample types. These include oropharyngeal swabs, nasal mid-turbinate swabs, and either healthcare-collected or healthcare-observed self-collected nasal swabs. What's nice about those is they are more comfortable to collect, and most of them do not require specific PPE use, especially if self-collection is performed. So, that's a great thing.

Another piece of this, though, is that testing has really been limited in the past by the availability of testing re-agents, and we are working very hard across the federal government to solve this problem. You may be aware that in your state, there has been some recent effort to get collection materials, including more of these collection swabs, as well as transport media, including viral transport media and saline out to every state, to support the increased testing goals. We are also working to identify large re-agents, or large platforms that have sufficient re-agency support testing. This is primarily through the Thermo Fisher and Hologic platforms, and those are largely run at large reference labs. And so, I think that's a cornerstone to much of the testing.

There are also point of care and near point of care diagnostic test platforms, and I know there is a lot of demand for those, especially in settings where decisions need to be made on the spot. The problem continues to be that the demand far outstrips the supply there, and so we are working to increase that supply, and also to help to prioritize. That, as well, being led out of the Task Force Diagnostics Group, Dr. Tammy Beckham and others at NRCC. So, that's all about diagnostic testing.

The other testing we have is serologic testing. This is evidence of past infection, and it cannot be used for diagnostics, unfortunately. So, the problem here is I think it is unclear what exactly a positive serology actually means. It certainly means exposure, but we do not yet have protection, and we can't yet say for sure whether the presence of antibodies is protective for the people who have them. So, we continue to work to develop the evidence that we need in this space, as well as to continue to evaluate the assays that we use in serology testing.

I think that is all I have to say at this point, but I will be happy to stick around and take questions later.

Ron Yee, MD, MBA, FAAFP:

Thank you so much, Drs. Koonin and Limbago, for those details. I think those on the front lines appreciate the technical approaches of the testing, so thank you so much for that. You know, the objective of these calls is really to provide practical input from and for the health center field, and that's why today we lined up having a network present, a primary care association, and a health center. So, next we'll hear from Fred Rachman and Andrew Hamilton of the AllianceChicago Health Center Controlled Network. Fred?

Fred D. Rachman, MD:

Great. Perfect. All right. Well, good day, and thanks so much for the invitation to contribute to today's conversation. We're both honored and humbled to follow such esteemed leaders and experts. Along with the rest of the nation, we at Networks of Health Centers are eager to leap forward into efforts to reopen. You know, widely looked upon... If we could advance the slides, or do I do that? A-ha. Okay.

In this widely looked-upon thought piece, Scott Gottlieb and his colleagues pointed to capabilities needed to decrease our reliance on social distancing, and these include more comprehensive and truly representative data on COVID status, ability to recognize and promptly respond to signs of pockets of reemergence, and capacity to deliver emergency... Emerging. Excuse me... treatments and management guidance, especially to our most vulnerable populations.

We've all got a Herculean job to assemble testing capacity out of the separate institution parts of our health system that starkly have operated independently. To move to the more coordinated net we just described, though, we have to recognize some of the gaps that need to be addressed, including limited supplies and restricted reactive testing approaches, and the need to move to a more proactive strategic approach, and recognizing that management of COVID needs to be integrated with ongoing healthcare. We also need to include contextual data that would make the testing data more useful in understanding the natural history and behavior of the infection and planning and managing future phases.



Community health centers located in every geographic region of the country, and responsible for most vulnerable communities, have risen to the challenge in ways that vary widely depending upon the local environment. Among the more than 120 health centers at AllianceChicago touches, along with our close partner, Health Choice Network in Florida, we see a wide spectrum of testing activities, ranging from health centers that are only referring testing to sites that are actually identified as local public health resources for testing. As Jim noted, we're noting that our patients are amongst the hardest hit.

We're thoughtful about what the benefits are that health centers offer, to serve as a coordinated system. We offer a wide penetration into some of the most difficult to reach areas and populations. We have access to important contextual data, and have developed, supported by the health center controlled network such as ours, the data infrastructure and social relationships amongst the health centers and other partners, to aggregate data and promote uniform and rapidly evolving testing approaches and protocols.

We see our network role as helping the health centers aggregate and visualize data, to facilitate the various roles they play. We need to take leadership in promoting solid data collection, and that includes defining what data elements we should all be collecting. We need to promote partnerships with other key stakeholders and sectors. And ultimately doing what we were designed to do: Providing a shared infrastructure, economies of scale, and access to resources and expertise, that can enable systemic responses and strengthen individual health centers.

We've outlined, we've bookmarked, as we've fulfilled this role, that there are requirements we're responsible to meet, in order to develop a federated but systemic approach. These include data use agreements, data set standards and definitions, aggregation and visualization tools, a uniform approach to capturing testing for individuals not enrolled formally at the health centers, as we play an expanded role, appropriate data infrastructure and expertise, and the social network for collaboration and a shared vision. On the patient management side, it's important to address the case and contact management component that's tightly bound to testing. These include clinical decision support to promote adherence to testing protocols, workflows and decision trees to promote uniform management, patient engagement tools leveraging automation wherever possible, recognizing the volume that's coming towards us, population management tools, workforce training, and augmentation. So, let me turn it over now to my colleague Andrew Hamilton, our Chief Informatics Officer, who can give you a taste of the data views and analytics we've been evolving to support and inform these efforts. Andrew?

Andrew Hamilton, RN, BSN, MS:

Great. Thank you, Fred. If we could advance the slides to the next ... let's go to the one titled Data elements. Thank you. As Fred mentioned, we've put together an enterprise data warehouse approach that is using a limited dataset to gather information to support COVID surveillance. We've also done a similar approach to understand the shift in volume from in-person to virtual visits. And while we know that in-person visits continue to occur, we're also tracking COVID symptoms at the time of care to represent data similar to you would see in influenza-like illness surveillance methods. Today, I'm going to walk through our testing surveillance data to give you a sense of what we've been collecting and aggregating at the network level. The data elements to support this are listed here on this slide as you can see. Both are used to provide context to the data, as well as to also give us information about the

status of the patient at time of testing such as their symptoms and other demographic information that will be useful to help understand the movement and spread of the virus in local communities. Next slide.

This map here is an overview of our network and testing activities that have occurred starting at the beginning of the pandemic to two days ago. You can see here is just a simple scatter plot to represent where testing activity has occurred across our network. As you can see here, definitely impacting many regions of the United States. In addition to that, we're able to use this tool to drill down to state, city, and zip code level as you can see on the filters on the right. That allows us to be able to see both a national picture of activity and testing at our network, as well as of course what's happening down at the local level. As you can see, we track daily test rates across the network, and we're breaking that daily rate down by negative and positive results.

This is then a distribution of race, ethnicity, and age for individuals that were tested positive through that same time period. Consistent with other national and local data, we see here that the age distribution of those testing positive is in the demographic of 25 to 60 years of age, followed then by those 60 and older, as well as the 18 to 25 range. We're also noting the demographic spread of those tested positive, those 3,420 individuals across those total tests, the breakdown by race, ethnicity. In addition, we have similar views of data that highlight the breakdown by federal poverty level status, insurance status, and other key variables that we think would be useful to help us understand where the virus is impacting the community and at what level. Next slide.

To drill down to a local level, we've developed a heat map to help us understand the testing rate within a local community. This is an example of testing of all individuals across the city of Chicago. As you can see here from lowest, the lightest green to the darkest green, areas of the city as to where our health centers and teams are working to test patients. Next slide. Similarly, we're able to then drill down and look at the positivity impact of COVID testing within city areas of Chicago, and we're using this data to also superimpose or understand how social determinants such as the American Community Survey or other social determinants of health impact the individuals that are having positive test results. Next slide. To demonstrate another example, this is where we have a large number of data from another city or metropolitan area. This one is Houston. So, taking a similar approach to understand that we're aware, we're testing, and what communities we're able to test. And then the next slide gives you the similar view of the breakdown of the positive results by community area.

As was mentioned in all the previous discussions today, another very important element is to understand how to contact trace and follow up with individuals who may have been in contact with those tested positive. The next slide shows a brief screen print of a tool, of a population health tool we're using to keep track of every individual patient. Each row on this slide represents an individual who was tested positive, the date they were tested positive, and then to the far right you can see all of the contact tracing protocol that we put in place and the status of every patient in terms of whether or not that step of the protocol has been followed.

This population health technology lets us create cohorts of patients that are being managed by community health outreach workers or other healthcare workers that are working regularly with the patients that have tested positive to identify ways in which we can support and help them maintain social isolation and/or communication with critical resources they may need. Of course, in our



population that would include access to food and other social services that will help our patients be able to sustain social isolation through the periods necessary. So, with that, Dr. Rachman and myself thank you very much for your time today, and we'll be on to answer questions at the end. Thank you.

Ron Yee, MD, MBA, FAAFP:

Thank you, Andrew and Fred. Wow, what detail you have gathered there, so we thank you so much for that. Next we'll move to the Alabama Primary Health Care Association. Mary Hayes Finch, are you on the line?

Mary Hayes Finch, MBA:

Good afternoon. This is Mary Finch from the Alabama Primary Health Care Association. Thank you for the opportunity to share the work of our health centers across the state during this time. I want to start to give everyone on the call just a brief overview of our landscape in Alabama. We have 17 health centers across the state that serve over 350,000 individuals annually. Almost 50% of those patients were actually uninsured, which is not unusual for health centers to have high percentages of uninsured patients. What is unusual is when we compare the 50% of uninsured patients in Alabama against the national average for health centers, that average is 23%, so there's a significant variance between our in-state average. Additionally, our patients, about 29% of them, have Medicaid. Compared again against the Medicaid coverage seen in the national average of about 50%. 90% of all of our counties in the state are designated as medically underserved areas, and unfortunately, we still have the third poorest health outcomes in the country.

In the best of times, our health system is incredibly fragile. And what we've seen is it is even more so as we face the public health emergencies, and particularly in the current environment that we're in. It also though has continued to highlight the critical role that Alabama's health centers play, really as the cornerstone of Alabama's primary care safety net. When Alabama's first statewide mandatory public health order was issued, 30% of the health centers were already organized and providing screening and testing services across the communities. That is now at 94%. Those testing processes have been set up through four primary tools. One of them is more of a traditional testing at an existing health center site in a designated location. The second is the establishment of walk-up clinics, primarily outside clinics where individuals from the community and patient panel could come for screening and testing.

In addition to that, there have been a tremendous amount of effort and experience developed across drive-up testing environments, and we'll talk more about that in just a few moments. The last area that we have used is teams and mobile clinics that are able to be deployed to hotspots or to low testing counties across the state as deemed appropriate. A health center in Alabama was the first to stand up a drive-up testing event, and it still is the largest that has been held in the state, screening in one day over 760 individuals. During that process we've been carefully documenting the process of testing best practices. And in fact, when you hear from Christ Health Center you will hear about their documentation through an instructional video that has been shared not only across our Alabama health center network, but across the country to colleagues so that we can all learn from the experience that Christ Health has had.

On the next slide, quickly want to show you just an image of our state and where the health center resources are. You see the blue dots represent health center sites across the state. All of those sites,

with the exception of one health center, are actually screening and testing within the health center practice. The other locations that you see noted are health center sites that have opened to general public testing, as well as where our mobile resources are that are available for deployment into areas, with additional areas that we have negotiated agreements and partnerships that help host sites in areas that don't have local testing. Our focus at this point is in low testing counties. We are currently engaged in developing and actually planning to expand health center testing in the areas that you see shaded in gray. Those currently represent Alabama's low testing areas, where we are screening less than 75 patients per 10,000 individuals per week. So, it is a privilege to be on the call. I'm excited for you to hear more directly from the front lines and from Dr. Robert Record who's the CEO of Christ Health Center.

Ron Yee, MD, MBA, FFAFP:

Thanks, Mary. Thanks for the work from APHCA. So, Dr. Record, we'll bring you up with your team.

Robert Record, MD:

Thanks. Thank you so much. We're so glad you can go to the next slides. So glad to have a great relationship with our state primary care association, Mary and the team at APHCA do a fantastic job. Our relationship with her has made it possible not only for us to exist, but to greatly expand our mission. We're a mission driven organization as all of you are. At every point we know exactly why we do what we do, and every team member that works with us knows exactly why we do what we do. COVID brought great change and really took the what of our why away from us. What we did had to change. You can go to the next slide.

March 13th, we had 18,596 patients and you can see how our why has driven our what for years. You can see 50% growth, 50% growth, 50% growth. We're not afraid to grow. Our mission requires us to grow. You can see, just like Mary said, that Alabama should be suffering tremendously, from all research from COVID we're unhealthier. I think we're fantastic and the best place to live. If anybody wants to challenge us on that, we're quite happy to be here. We're fat but by golly we're happy. All the social determinants of health are quite the opposite of in our favor. We had 18,596 unique patients last year and we had zero ability to test. As of March 13th, we talked to every public health leader we could talk to, including our state health officer who's a fantastic gentleman, and said, "How on earth can we get a test?" There was not an option and said, "How on earth can we get a test and there was not an option for any of our patients and half of those are uninsured so you can imagine their access to any community testing was quite limited." We can go to the next slide. The question wasn't if we were going to test, it was how. And we were able to find a local partner who has a lab. We went out and tested with him. This gentleman we had just met in the community, and he was doing mass testing but he was trying to be the lab and the doctor ordering the test. We tested with him on the front lines for a day and at the end he said, "I'm worn out. I can't be both the lab and the ordering physician. Dr. Record, you and your church do a lot of logistics. I happened to go to a very large church, it was little when we started it. Would you all be willing to do some logistics for us and would Christ Health Center be willing to really take the lead as the ordering physician?"

We didn't think it was enough to just order tests and say we screened people. We thought that every person who came in a car to see us needed to be regarded as an individual, needed to be regarded as a patient and just like we had felt Dr. Thomas's pain in his lab, we needed to be able to feel the pain of the people we were testing. We had 42 N95 masks when we decided we could test a couple thousand

people in a week. We had a total of 42, so we had to figure out how we could do testing without burning through PPE. You can see our results there. To date we've tested, now that number has grown, 3,121 patients. Our positive numbers are very low and it's almost unexplainable. In Alabama, we did just like you did where you had to have symptoms and all of those things.

Of the 98 patients we screened positive, every single one of them has had a call every day that they were symptomatic from our lead COVID physician and only two out of 98 have ended up hospitalized and zero have ended up dead. So, I would call that tremendous success. We can go to the next slide. All of our solutions and all of our pivots have really revolved around shared pain. It's unreasonable for us to prescribe solutions to a community without feeling the pain of the community. Focus groups simply won't work. The reason we were able to get access to COVID testing is because the lab saw that we cared enough about their need that they trusted us to go forward. Next slide please.

One of our key statements, culture is king at our organization and we really are. We harp on it a lot is that we're only as healthy as our relationships, and the great thing about living in a middle-sized town is we have relationships with all the power brokers and also the people in pain. This large church was willing to let us use their very big parking lot. Not only did we use their very big parking lot, we used their entire team. Their creatives, their IT team. And at our height, we were able to check 760 patients in a day. We had planned to do that for weeks, but as we were getting very busy, the big university in town also came available to do mass testing. So, it wasn't so much that we were needed there and we only wanted to do work that we were needed. And while we were testing people over and over and over again, we heard, "I have a fever and a cough, and I have a cancer diagnosis," or something like that.

And over and over again, we heard that and they said, "They won't let me come to the ER. They won't let me come to my doctor's office. How do I get seen?" So, we realized we needed to pivot again. We keep hearing this word pivot, but all of our pivots were how do we go back to the north star, which is our mission? So, we can go to the next slide. Beyond testing, let me go through the next two slides. In testing, we use volunteers heavily and then we documented everything we did. If we saw 10,000 patients over three weeks, which we could have easily done, it would have only touched those 10,000 patients. But if we came up with systems that other people could easily follow and then gave those away and put the cookies on the bottom shelf for people, then we were really a blessing to the community.

And so that's available to all NACHC members. We've had clinics across the country download this and use our drive-up testing systems, everything from every document, to how we used our portal with Athena, to how we check people in, to how we billed, and how we close the referral loop. All of that's documented there. And so that's available to everybody. But past mass testing, we saw a need to treat, and that would be the next slide. And we had this concept of bubble clinic, and I wasn't quite old enough in the seventies to remember the awful movie of Bubble Boy, but how could we use plexiglass and plywood to create a safe testing environment?

So those little bubble clinics you see there, there are four of them. They are sealed to air. We can pass through testing kits without exposing patients, or patients exposing us. There are stethoscopes going through that plexiglass. There are gloves going through that plexiglass so we can actually touch patients, see our patients. Came up with a clean way for patients to get into our x-ray suite, which is across the

parking lot. Thank you HRSA for allowing us to have a temporary site. This was our neighbor's building and we're able to sterilize each of those rooms with isopropyl alcohol from floor to ceiling, and every single thing in between each and every patient, so no patient and no doctor exposes one another. In fact, our first COVID diagnosis came March 14th on a nurse, and she had traveled to North Carolina and that's how she became positive. And we have not had a single COVID diagnosis on our staff since then, despite testing more than most. Next slide.

The community said we're glad that we can drive there, we're 1.6 miles from four major public housing projects, and the housing authority was very thankful that we were doing our bubble clinics and so was the mayor of Birmingham. They called us again and said, "We think you're meeting the need. There are a few people without vehicles, would you be able to come to the housing communities?" And we came up with various ideas like retrofitting Conex boxes to using a mobile unit. And I called my friends in Staten Island at Beacon Health who are incredible and they said, "None of those ideas would work for us. How do you create something that we could replicate in a place that is not full of Home Depot and rednecks like you guys?" And so, this is our redneck solution here, and I call myself one of those unfortunately.

That's a modular wall, so every one of those can be set up. That entire thing breaks down into individual pieces in 20 minutes and sets up in 20 minutes. They're eight check-in areas. Again, almost no chance for a patient to transmit disease to the provider or the provider back to the patient. Each one of those booths is sterilized with isopropyl alcohol between visits, and that's been a fantastic partnership with the housing authority. And interestingly enough, we found much less busy than we thought we would find there. The city and the local health officials were very concerned that we were going to find hotspots, and though we didn't find hotspots, we were able to bring back data that said what we didn't know, is that there's not rampant disease moving through here. Where you see that set up right now, we had a patient's family referred to us from the major tertiary hospital in town.

She died. She had not been our patient. All of her family became our patients after, we've been able to test them and now test a lot of their community. Next slide. This is at the end of the day who we are. Simple people willing to find any what for an amazing why. We know we're here to serve the underserved. We know we're here not to be an answer to people or for people, not to treat people like problems that are to be solved. COVID is an opportunity for us to dwell with and among patients in pain. To bear their pain, to suffer with them, to suffer for them so they might find freedom. Our next pivot will be the most interesting. How do we get back to somewhat seemingly normal operations while still maintaining a massive testing role for our community? We're partnered with Assurance Scientific. We've not been able to get more than 50 tests from our state health department, although we're working with them on the next pivot.

Assurance Scientific, and as we've worked with private partner Microbiology Labs, they tell us that they're at 25% capacity. So, if anybody's looking for PCR testing, we have massive access to it, and we're looking at serology testing though the data that has been waiting for us. We have started to, I would say dabble, I think other people would say we've entered in it quite a lot, but we have not found a good way to bring the FDA not approved test to market. We have been able to validate them through our lab partner, which satisfies the FDA. But how do you get to bill on that lab to the person's insurance if they do it so it's a more sustainable operation? That's a great question that you guys can answer better than



me. At the end of the day, we're not motivated by resources. We said we would test everybody before a single dollar came out, which we couldn't do it without you. Thank you.

We said we would use our reserves and then any uninsured person could come and we would cover it all ourselves. And we've said that from day one and we've been able to do a lot of that. And thank you HRSA, that the first week of this that I lost a massive amount of sleep thinking we were going to lose years of savings, that you stepped in and were more than a partner. You put the how to the what of the why that we were always committed to. So, thank you HRSA and I'll hang around if there are any questions.

Ron Yee, MD, MBA, FAAFP:

Wow, thank you so much Dr. Record. I think you all are a great example of the focus of health centers and our mission. So, thank you for doing that. Thank you for the innovation. And boy, that's quite a figure to say one of your employees has come out COVID positive with all those testing that you've done. We appreciate that so much and this is what the health center mission and spirit is about. We thank you for exemplifying that and for giving some very practical ways to protect your employees but also serve the community. I appreciate also that you guys decided this was a priority and you were going to do it either way, whether you had funds or not. So, thank you to HRSA as you mentioned for getting some of those funds out. I know NACHC worked really hard with Congress to try to get some of those funds in these stimulus bills and we are continuing to work for that.

I want to thank you all again for joining us today, especially want to thank Secretary Azar, Administrator Engles, our federal partners, Dr. Koonin and Dr. Limbago from the CDC, Jim Macrae from the Bureau and NACHC President and CEO, Tom Van Coverden. I want to especially thank you Fred and Andrew for your great insights from the front lines of what can be done with data and how specifically we can find out what's going on with our patients to provide better healthcare. Mary Finch, thank you for setting up the discussion from the Alabama Primary Healthcare Association. Great work you're doing at the Association level and thank you, Dr. Record and your staff for all you have done at Christ Health Center. Great example of partnering with the community and keeping your focus, so thank you so much for that.

I do want to recognize our nurses, as yesterday was the start of Nurses Week, many of those on the front lines who are sacrificing themselves and just to serve our patients. So, let's continue to celebrate Nurses Week, and as we celebrate the Year of the Nurse. Also, I want to let you know that there'll be a link to all these resources and slides. They will be on the NACHC website under resources. Also, there was a great webinar yesterday put on by Health Choice Network and AllianceChicago. They focused on testing and actually had Quest Laboratory with some very good information on there. So please go to the NACHC webpage at www.NAC.org/coronavirus and we will be back in two weeks. So not next week, but in two weeks, Thursday May 21st at 1:00 PM Eastern time.

At this time, what we hear from the field, we'll be discussing what re-opening looks like, so re-opening will be our topic in two weeks. Thank you all for joining us. Please stay safe and healthy and know that we are with you to support you in this health center COVID-19 response. Thank you everyone and be safe and healthy.