

Leading in the Crisis: Flattening the COVID-19 Curve
Roadmap to Re-opening and Re-imagined Care

Thursday, May 21, 2020

1-2PM ET

Speakers:

- Lisa M. Koonin, DrPH, 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
- Kim Schwartz, MA, Chief Executive Officer, Roanoke Chowan Community Health Center
- Betsy L. Thompson, MD, DrPH, RADM USPHS, Director, Centers for Disease Control and Prevention
- Brian Toomey, MSW, Chief Executive Officer, Piedmont Health
- 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. We'd like to present our national partner update today as we align efforts with the CDC, HRSA/Bureau Primary Healthcare, NACHC, and health centers across the nation in our COVID-19 response. As we continue to address this pandemic with health centers in different phases of incidence or levels of prevalence, we need to start thinking about what it looks like to begin the reopening and re-engagement process. We've transitioned to a two week or every other week webinar schedule and wanted to continue to receive input from the health center field on what is important to you.

During the webinar, today through the chat function, please let us know about COVID-19 top of mind areas of need or challenging topics you would like us to address going forward in our every two week webinar series. Thanks for our interactive dialogue up to this point. Today, we'll address reopening and re-imagining the care as we look toward emerging from this pandemic. The healthcare system, and specifically care through community health centers, will look very different. We'll hear from our federal partners from the CDC and HRSA Bureau of Primary Healthcare, and from two health centers from the front lines seeking to reopen services as they continue their COVID-19 response.

A few housekeeping items to start with, for those joining via internet there will be content slides for some of the speakers as they present today. The recording transcript and slides will be posted on the NACHC website after the call. You can also find them under the Resources tab link on the left bottom corner of the page as you attend the presentation today. You'll see other slides rotating which will give you instructions on how to ask questions and to ask a question during the panelist presentations. You can do that then or during the formal Q&A time. Please click on the Question button on the bottom left corner of the screen and please note to whom you would like the question directed and then type in your question. If you want to chat with other participants or communicate with NACHC during the call, please do so using the chat function. Again, please let us know about top of mind topics and things you would like us to address in the near future.



If you're having any technical difficulties, you can click on the Request Support button and someone will get back to you immediately. We'll try to group the questions around similar topics when we get to the Q&A time to make it more efficient. Questions we can't get to will be added to our COVID-19 FAQs posted on the NACHC website.

For today, our speakers will be Dr. Lisa Koonin, Senior Advisor to the CDC COVID-19 Response Team Centers for Disease Control and Prevention and she'll be joined by CDC colleague Rear Admiral Dr. Betsy Thompson, Senior Advisor to the Command Team, COVID-19 Healthcare Resilience Task Force of the National Response Coordination Center Centers for Disease Control and Prevention. Tom Van Coverden, NACHC's President and CEO will follow. And next we'll have Jim Macrae, Associate Administrator Bureau of Primary Health Care, HRSA.

Following our federal partners, we'll hear from Kim Schwartz, CEO at Roanoke Chowan Health Center in Ahoskie, Virginia. And from Brian Toomey, CEO of Piedmont Health services in Chapel Hill, North Carolina. Dr. Koonin from the CDC will begin our federal updates. Dr. Koonin?

Dr. Lisa Koonin:

Thank you so much, Dr. Yee. It is such a pleasure to be back on the line with all of your folks today. Again, CDC is very grateful for all the work that you're doing on the front line and continue to serve the public as part of this response and what you do every day, even when there's no response.

I want to first introduce you to a colleague who will be joining these calls later on. Dr. Catharine Riley, who is currently working on CDC's COVID-19 response. She is leading a new unit that was just activated that is focusing on reaching FQHCs in vulnerable populations. Going forward, she will serve as the new point of contact for NACHC. You'll hear from her in future calls. I'll be rolling off this part of the response at the end of the month and just want to thank everyone for having me as a participant of your calls.

But I'm especially excited and very pleased to introduce our CDC speaker today. Rear Admiral and Dr. Betsy Thompson, a leader in the national COVID-19 response, who is serving as the Senior Advisor to the Command Team COVID-19 Health Care Resilience Task Force of the National Response Coordination Center. Dr. Thompson?

Rear Admiral Betsy Thompson, MD:

Thank you and good afternoon. It's a real pleasure to join you all. I won't go into it but I have a long history of involvement with community health centers and really appreciate the work you all do. At the onset of the COVID-19 pandemic, as you all are aware, CDC recommended that healthcare systems prioritize urgent visits and delayed most elective care in order to mitigate this threat of COVID-19 in health care settings and among communities. But almost immediately, we began here, and I'm guessing you did too, anecdotal reports about deferral of urgently or emergently needed care, which was never advised. Many of those conditions are quite relevant in the communities we all serve. From meeting decreased emergency department visits for conditions like diabetic ketoacidosis and stroke, to reduction of initiation of chemo and radiation therapy and many other conditions.

The CDC and The National Response Coordination Center had began increasingly receiving inquiries from health care professionals and healthcare systems about how to resume or expand services, particularly as community transmission decreased. So, one thing I've worked on during my time as a,



what we call the NRCC, that National Response Coordination Center, in partnership with CDC Task Force is the framework for healthcare systems providing non-COVID-19 care during the COVID-19 pandemic. Now, I know that title doesn't roll off the tip of your tongue. But, if we can see the one slide, and this is also in the resources that you have available so you can find it.

The purpose of this document is to provide healthcare systems with a general framework for delivery of non-COVID-19 health care during the pandemic. It's a general framework for making decisions about delivering care safely during this time. We hope that the table you will find in the document, which the document itself is also in your resource section, will be particularly helpful in making decisions about delivering care safely during the pandemic. So, this slide shows you the first part of the framework, the document itself, as well as some key considerations.

The table within it that I mentioned is organized by two key principles. First, is the likelihood of patient harm if a service is delayed or deferred. Second, the level of community COVID-19 transmission that is occurring. As the pandemic continues, we know that health care systems have to balance the need to provide necessary services as well to minimize risks to both patients and health care personnel. The framework itself asks that potential harm be considered. If patient harm is highly likely, such as would be the case if someone suffered a heart attack, stroke, certain cancers, etc. If patient harm is highly likely if that care is delayed, then it should be provided, regardless of COVID-19 transmission.

Note, we've provided a few examples. They are not meant to be exhaustive or prescriptive, they're illustrative only. But I wanted to draw your attention to the fact that for that highly likely to have harm, we included things like well-child visits for newborns. There's sort of three tiers to that highly likely harm. Where harm is less likely, you really need to consider local conditions before deciding whether to deliver care. So, in that, we included examples like many pediatric vaccinations, musculoskeletal injuries, and certain planned surgeries. For conditions where patient harm is quite unlikely, deferring care until community transmission is essentially nil is probably still the most appropriate decision to make. But potential patient harm really is best assessed by the individual clinician and patient taking multiple considerations into account. So again, we're not trying to be prescriptive, we're trying to provide some useful guidance here.

The framework also includes a few additional key considerations for health systems and health care personnel to consider. First, that regardless of patient harm and transmission that healthcare systems must remain able to respond to a surge in COVID-19 cases. Second, care as always, and I know you all know this, must be provided in the safest way possible. Third, services may well need to be expanded gradually in many locations. So, in terms of the first one, the surge capacity, healthcare systems must be prepared to rapidly detect and respond to an increase in COVID-19 cases in their communities. To do that, it really requires staying informed, consulting regularly with your state or local health department for region specific information and recommendations, as well as monitoring trends for local case counts and deaths, especially thinking about populations at higher risk for severe illness. It also means that you must be operating without crisis standards of care. That means having adequate staffing, personal protective equipment, and other supplies. I do want to make it clear that, I think you probably all looked at CDC's website a number of times, but we do have a number of tools to help healthcare systems respond to a surge in cases as needed and some setting specific guidance as well.

The second key consideration, providing care in the safest way possible regardless of the level of harm



that might be incurred by a patient if care is deferred, regardless of the level of community transmission. We are recommending the use of telehealth services whenever available and appropriate to minimize the need for in-person services. I know Community Health Centers have been leading the way in many respects in providing telehealth services. Also, you need to follow recommended infection control practices to prevent transmission of infectious agents broadly, but also those specific to COVID-19. So, that would include screening all patients for COVID-19 signs and symptoms, universal source control, and the infection control practices specific to COVID-19, particularly to the setting that you practice in.

The third, considering that services may need to expand gradually, you have to make decisions for expanding care based on the local epidemiology. As I said, in concert with recommendation from your state and local officials. We would recommend that you prioritize those services that, if differed, are most likely to result in patient harm. That would include prioritizing at-risk population who would benefit most from those services. For example, those with serious underlying health conditions or those most at risk for complications if care is delayed.

Another document that is included in the resource section, and it's quite lengthy, it's gotten a lot of press or got a lot of press before it was released, very little since it was released, but you may want to become familiar, at least with the gating criteria and the phase-specific thresholds, I think on page six or seven of the document titled "CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again."

Finally, one other really important thing to keep in mind throughout this pandemic, is how it is affecting the whole of our health system and the ripple effects into care seeking and delivery. Those effects may vary from one community to the next. We've all seen them so far ranging from things like decreases in vaccination doses ordered and administered to the significant decreases in emergency department visits for heart attack and stroke symptoms that I mentioned earlier. I'm going to end there. I thank you all for what you're doing to provide quality care safely and protect your workforce amidst the challenges of this pandemic. I look forward to your questions. Thank you.

Ron Yee, MD, MBA, FAAFP:

Thank you, Dr. Koonin and Dr. Thompson, I think it's really nice for the health centers to hear that balance that the CDC understands of our ongoing care for our non-COVID-19 patients. We appreciate that so much in the balance that you presented of not forgetting about those folks amidst our response to the pandemic, but also protecting our patients and our staff alike. So, thank you so much for the balance.

Ron Yee, MD, MBA, FAAFP:

Next, we'll move on to Tom Van Coverden, NACHC President and CEO, Tom?

Tom Van Coverden:

Ron, thank you very much. I want to say a very, very big thank you again to our guests and sponsors and all the people listening to this meeting. Let me just say to our friends at CDC, Lisa, Dr. Thompson, and Dr. Riley that will be working more and more with, that we so appreciate the work you're doing and Dr. again, just please know how grateful we are for working with your agency so closely. And Jim Macrae for the Bureau of Primary Health Care, a HRSA agency, which oversees the health center program.



I just want to say, if anybody needs a letter to the President or to the public or to the Congress about the value, the tremendous value of your organizations, and how closely you are working with people down to the community level in some of the neediest communities, know that I stand and our entire organization, Dr. Yee, ready to sign any set of letters or write anybody that you would like. Just to, again, acknowledge the critical importance to what it is that you're doing and how you all, as a government, are working very, very closely with the health centers. Our deepest appreciation on behalf of all of us.

Dr. Thompson was addressing, from the immediate phase, now into the recovery phase, and getting back to how we treat normal patients that have been postponing or putting care off. I know a number of people are also trying to take into consideration in their planning, how many folks will be, once many of the benefits expire, left without medical coverage. The numbers are quite staggering. So, preparing also for that increased payload, as well as some of the schools and whatnot that are looking at trying to think about coming back or, even if they're not, what are we doing to make sure that we get the children in for their inoculations and other normal tests. As well as trying to get everybody in for their COVID screening that needs that.

I mentioned that there's so many innovative things going on, Ron, and I appreciate our speakers following this that are going to be talking at least on several of those models. But as many incredible things are happening, people are redesigning their practices and how they practice, both to deal with the COVID crisis, but also with the patients that have put off for, in many cases longer than maybe was needed, in health care situations.

I'm thinking of one gentleman I talked to, a doctor down in Mound Bayou, Mississippi, and I said, "What kind of things are you doing?" and he said, "Well, Tom, in addition to the drive-thru, we have set up several other sites to make sure that the clinic sites themselves are safe, that they're cleaned regularly." And again, communicating with their patients to get in to care, as well as doing things like ... And in this case, had free lunches for the entire county to get people in and they got hold of some of the very good testing equipment, the highest caliber test for the entire county, whether people were insured or had coverage or not.

So, I know Dr. John Freeman down there, just what an incredible job they're doing. At the same time, Ron, they went and worked with several of the churches and I know, for example, did the testing in several of the churches and had better than 300 who tested positive for the COVID virus. And the pastor who just passed away after two weeks of those tests being taken. He was identified having a problem. So, it's those kind of things and many, many more innovative things that our folks are doing. Our goal as NACHC is to, again, do what I think it is we've been doing as we move in this transition phase. First, making sure that our people all are provided with trusted information, whether that's from the CDC or whether it's from the Bureau of Primary Health Care and health professions, again, who are critical to everything that's going on. Thank you for that.

Secondly, bringing some of the expertise directly to you. Secretary Azar in a number of occasions, Administrator Engels, who now will be serving with the White House Task Force, and folks like CDC. Third, I think fighting for you and the folks that you serve by providing the advocacy and the knowledge base about the high risks in some of the minority populations. Again, how many are we serving? And we are, many. In the meatpacking plants, for example. How many are also providing care with hospitals or other health care providers and in nursing homes, etc. to link with the care. Again, the centers are not



afraid of going forward, but because they have the good information, Ron, that this webinar and other things that are being sent out, we're making sure they get the right information versus some of the misinformation that's all over the television too much.

Fighting, I think, for those people and suspending certain events to protect public health with our members who very much want to share information, knowledge, what's going on with innovation, etc. and doing that through virtual learning opportunities. For example, canceling our Community Health Institute, often with over 3000 attendees, the number of ongoing training sessions, information sharing sessions that are going on, as well as a totally remote alternative now to our fall meeting, which the plans are being finalized for, are being set. It's amazing to me how many members are saying they miss and they very much want that communication with their colleagues across the nation.

Lastly, to continue to fight on the resources that you need. If you know there's money from the current bill, like current legislation H.R. 3.5. That, for example, especially for Medicaid providers, which has not yet been released, it is being held back as the Centers for Medicare & Medicaid (CMS) is holding back until they hear from several states before they can calculate the distribution. But again, that should benefit a good number of health centers. As well as, and I think most of you are aware, of the current HEROES Act, H.R. 6800, which passed the House and now is pending before the Senate, providing an additional \$7.6 billion to health centers for innovation. As well as significant funding available to CDC, to HRSA, and to the programs that they administer, including health centers to further make sure that they are there for the preventive care. Again, I know the Deputy Secretary spoke with us about the immunizations. What are we planning to do with that if schools are not starting up? So, we have a number of centers already aggressively moving on that front, again, linking with nursing homes and other areas, or other employers with large employee populations. What are health centers doing in there and are asking for reports back.

So, to make sure that we continue to do those things I'm extremely proud of the health centers and the work, the incredible work, all of you are doing. Just know that we're with you every step of the way, as are all of the other partners on the phone with us. And with that, Ron, a big thank you to you and the entire staff for all that you're doing. Happy Memorial Day for everybody here. Thank you.

Ron Yee, MD, MBA, FAAFP:

Thank you, Tom, and thank you for your leadership. Next, we'll move to Jim Macrae from the Bureau of Primary Health Care. Jim?

Jim Macrae, MA, MPP:

Great. Thank you, Ron, and thanks to all the NACHC staff. Thank you, Tom. Big thanks to our CDC colleagues, Lisa in particular, thank you for being part of these calls and really being part of all the work we've been doing to help support health centers. So, thank you for that. A huge thank you, of course, to our presenters today and, really, to all the health centers out there. We continue to be amazed by all the incredible work that you all are doing and know that it is not easy. Please know that we are absolutely thinking about you every day and anything that we can do.

I just wanted to share a few things in terms of my update. First, and this is hot off the press, we just did our most recent survey data in from the health centers. It will actually be published officially tomorrow, but I'll give you the sneak peek. We had almost 75% of health centers respond to this survey. So, a huge thank you to those that submit that information. It really is critically helpful to us in terms of really



understanding what's happening on the ground and across the country. Please continue to do that. We actually extended the deadline for those surveys by an extra day to make sure that we could get as many health centers reported as possible.

In terms of some of the highlights, 91% of health centers now have testing capacity as they're reporting. Almost 69% are doing drive-up or walk-up testing. Again, most of the results that we're getting back from our tests are taking about two to three days, about two thirds of the health centers are getting those results back that quickly. In terms of the number of individuals tested, we reached almost 155,000 just last week. So, that continues to go up every week. Of those that were tested about 57% were racial or ethnic minority patients. Of those that tested positive about 72% were racial or ethnic minority patients. We had a total of about 19,000 people that tested positive in our health centers last week.

Some good news is that the weekly visits compared to pre-COVID weekly visits is continuing to go up, we're at almost 60%. So, that's really some positive movement there. But we continue to have a number of sites closed, still over 1900 sites closed, over 600 staff have tested positive for COVID just in the last week. A percent of staff that are unable to work is at about 10% nationally. We continue to see significant use of virtual health care which is not surprising. But it is going on a downward trajectory, which we think means, based on your feedback and comments to us, is that more of you are able to do more in-person services. We're at about 49% of health center visits are now conducted virtually.

We continue to see good movement in terms of adequate supply of PPE, right around 85% to 95% there. We also were very pleased today to have a technical assistance webinar for our FQHC Look-Alike partners. They were eligible for funding in the most recent round of the COVID-19 resources for health centers. There's a total of \$17 million available for our Look-Alikes. They're a key part of our family, so we were really pleased to have that call today at a big representation.

For the health centers related to the coronavirus testing resources that we put out a couple of weeks ago, just a reminder that your submissions are due June 6th, so please get those in. It's critically important. The last item I just want to touch on are the progress reports that we're going to begin collecting in early July from every one of the health centers for the different funding that we put out. What we're asking health centers to report on are what we see as some of the key areas, not just in terms of how you're using the resources, but even more importantly, how you're gearing yourselves up for re-opening, which we know is going to be the rest of the focus of today's call. So, what we are asking folks to report on is, what are they doing with respect to both their staff and patient safety, especially around infection control? What are you doing to make sure that the health center continues to stay a safe place, both for our providers, for our staff, as well as for our patients?

A second key area is testing. That is absolutely critical as part of re-opening, in terms of doing COVID-19 testing. We recognize that pretty soon, if it's not already starting, there's going to be antibody testing and again, both for our own staff as well as for our patients, to really help the communities understand what the impact is, especially on the populations that we serve. The third category is really around maintaining or increasing health center capacity and staffing levels. As we start to see folks begin to ramp up, what's that going to look like?

We definitely recognize that COVID-19 and its impacts have had a significant impact on our health centers. It really has tested all of us. But it also has opened up some new possibilities in terms of how

we're delivering care and how we're organized and how we do our work. The biggest one and most, I think, visible one is around virtual health care. What will that look like in the future? We do anticipate that health centers across the board will likely do much more virtual health care in terms of what they're doing. But what is that right balance between in-person and virtual health care, especially as we begin to get to the later phases around COVID-19. But we're asking folks to talk about that.

Then, of course as I mentioned, telehealth. What you've been able to do in terms of increasing your capacity there. Then, if there are some minor renovations and changes that you need to make in terms of your physical work structure. Whether that's setting up those mobile testing facilities or creating barriers or different things in terms of how healthcare is delivered. I know this has come up quite a bit around our dental services. So, we're asking folks to begin to report on all of that. We really see these as some of the key activities not just now, but into the future.

I think that's the most important part of what we're trying to think about is, of course, addressing the immediate needs and what we need to do to keep health centers open and operating. But, also how can we make sure that health centers and the patient populations that we're serving ... And to be honest, some of the positive changes that we've been able to make, let's make sure that they continue going into the future. So again, a huge thank you for NACHC for putting on these calls and really look forward to hearing from our guest presenters on the front line. So, thank you all again. Thanks a lot.

Ron Yee, MD, MBA, FAAFP:

Thanks, Jim. Appreciate those numbers and yes, the activities in the health centers are pretty amazing in their response, so thanks again to our federal partners and Tom Van Coverden, as we seek to align and support each others COVID-19 response efforts. Next, let's hear from Kim Schwartz, CEO at the Roanoke Chowan Health Center. Kim, can you share what you have for us today?

Kim Schwartz, MA:

Yes, thank you, Ron. I do want to let you know that we're not in Virginia, we're in North Carolina, but right up to the Virginia line. It gets confusing those unique names of wonderful service areas that we all have and serve. I am honored to represent the rural community health centers and what we do out here in the rural and feel really honored to be able to talk a little bit about this and grateful for the invitation.

So, we are an FQHC and we are definitely a rural FQHC serving about five counties in northeastern North Carolina. We basically serve agricultural-based ... We're a designated migrant farm worker health center, as well. We have real issues around generational poverty and structural racism. We're 65% African American. This is one of the unique cases in North Carolina that we had to address the issues that have been long-stemming and this is what we do in the community health center world. We do that through primary care, behavioral health, and we've had a telehealth culture for quite a long time. So, we've been really fortunate to be able to get a lot of support from HRSA around that. We've been doing remote patient monitoring since 2006. When we were needing to make quick and rapid changes to be able to access our patients, we had the telehealth culture already.

For us, nothing is easy in any way, shape, or form, but we were able to convert to that rather quickly. Beautiful pictures there of our agricultural-based area and just really grateful for how everyone has managed that so quickly. Ron, that next slide. How we're doing care now at our community health



center is on multiple ways. We are still doing in-person, that's about 25% of our visits. 45% of our visits are virtual. So, you see my lovely Dr. Charles Sawyer there, 87-years-old doing a virtual visit right now there. He actually is ... 100% to 90% of his visits are virtual. So, when we say that, "Okay, Boomer ..." He is way past boomer, he is actually doing a fantastic job that way.

One of the other ways that we're doing, of course, is telephonic. That's about 30% of our visits. 40% of our virtual visits are through our portal in MyChart and on the hot spotting. So, you see a number of wonderful staff out there handing a Kindle, which we've now converted to iPads, a little bit bigger, but we have 35 Kindles in our school-based health program that we were able to quickly convert into using hotspots. Out in the rural here we're a broadband desert. Only about 50% of our patients have access to broadband, either because it doesn't reach or they can't afford it. We had to quickly come up with some kind of system and we really wanted to be able to use virtual as much as possible. So, 40% of our virtual visits are through hotspots at our locations. I think I shared that workflow with everybody last week. Cheryl sent that out.

The additional things that we're doing are curbside testing and there's our team doing that there. We're also a designated migrant farm worker health care organization. So, we're working with our agricultural workers as well, too. We're part of the OCHIN Collaborative, the Health Center Controlled Network, and so fortunate to have a MyChart portal to be able to activate that rather quickly. But we also are using all the other allowable access to care with virtual care with our patients now.

About mid-April ... And I think because we needed to try the Lifeline, that there was a future in front of us of some other ways other than what we were doing now, because the anxiety around just being limited to virtual and telephonic. Fortunately, with our hotspots, we're able to get vitals from our patients and be able to do lab work and things like that. But our team began to recognize that we were going to have to be diligent and intentional about planning for reinstatement. That's the word that we use is reinstatement because we wanted to be able to reinstate our in-person and recognized that's how, as Tom mentioned earlier about the immunizations and we are seeing children under the age of two ... But we got school that's starting back up again and we want to be able to access that. Then, the chronic disease management using our ADA sites and all the things that we need to do to be able to access that.

We designed two groups to start out with and have been meeting for about four weeks now. Our clinical reinstatement group and, of course, they're focusing on the major issues around addressing clinical staffing and workflow and locations, being able to expand our hours again. When everything started in March, we brought everyone into the same set of hours of 8:00 to 5:00 predominantly through the week and reduced our extended hours because we were really concerned about staffing and being able to access care. We suspended our Saturday hours and so this group is looking at getting back to expanded hours, getting back to our Saturday hours, and using all the tools we have at hand to us like the virtual, in-person, hotspot, telephonic, remote patient monitoring and how we can do that.

From the first person that we tested, which we've now tested nearly 230 patients, our county is the only testing site outside of the hospital. We started case management from day one of that person that we first tested. We've been monitoring about 100 of those patients once they've been positive and as they converted their testing. So, recognizing that the majority of them are at-risk comorbid states and how do we continue that? We had our remote patient monitoring program that enabled us to do that rather



quickly. As we are addressing clinical guidelines, we want to be able to keep our quality levels up and patients that are medical home criteria. Also, as we're transitioning to community wide testing. 40% of our providers are in the at-risk category, not unusual I think, for most community health centers. We have some seasoned providers and then we have some providers that are pregnant, which that puts that into that category.

Then, our operational reinstatement group is focusing on how to bring back the remote worker. Just like everyone did, we needed to get folks out of the community and into the home. We are looking at the assessment of each worker in position there, what is necessary to bring back? What phases and stages we do that with? How we're going to keep our staff that are at-risk, where are we going to locate them? In the facilities or at home? What does productivity look like? We're at 85% capacity, which is great. But that doesn't mean we're at 85% of revenue. And those are kind of the components that we're examining as well, too.

Solidifying our supply chain resilience is a major issue for us, as it is for everyone, as we're broadening our community-wide testing and expanding services to more face-to-face. The staff sustainability and enrichment. I shared this with our North Carolina Primary Care Association, or hazardous leave policy that we adopted from one of our colleagues up in Alaska. We didn't have money to give for hazardous pay. So, March 30, we developed a policy for those that are forward-facing, or we call patient-facing, beginning March 30 they were able to receive double accrue for their vacation leave. Those folks that were coming into the center that couldn't work remote for multiple reasons, some of it because we don't have broadband access or equipment, they are getting 1.5 increase on their vacation leave. We keep that and track that separately and it's a temporary policy to really acknowledge and address the extra workload and the hazardous access.

We have been so fortunate that we've not had a single positive of our staff, as much work as they've done with 25% being patient-facing. Next week, we are adding a respite leave day once a month for all patient-facing staff. That's a day that they have to take and we'll pay that through sick leave. But it's a day to encourage them ... Everybody is working so hard and they don't want to let each other down. As you know, the empathy fatigue that sets in, we want to recognize that and so, we have morale boosters and all of that going on, just like everyone else is doing as well, too. We're glad to share any of those policies as well with folks.

The next slide. As we've been making this transition, we're looking also at our capacity building. So grateful for the federal funds, really how important that is to build on what we need to do to carry into the future. Those are the things, like Jim had mentioned, what we need to do with our facilities. We're looking at buying refrigerators and larger ones to be able to ... When we get COVID immunizations in and vaccines in, we're gonna need additional space. The touchless bathrooms and doors and things like that. All that we're going to need to be able to prepare. We just can't think of what's in front of us, we have to be thinking the long game and how we address that.

All my colleagues that are in the health center world know, I say all the time, every time we're in strategic planning, I say "Movements have to move." Jack Geiger is one of my heroes and John Hatch is a good friend. Medicine may be the way we got in the door, as our friends at Mound Bayou had said. So, this is me quoting this, it's probably not original. But I say, "Testing is the new way we get in the door." So, who are these populations that we want to be able to reach out and target test as we're doing our

community-wide testing? We want to be able to be intentional about connecting them to us as a community health center, to the patient-centered medical home, what does that look like?

So, we're doing some really intensive work with our communities, our health department, our chambers of commerce, educational institutions, economic development, other community health centers in the region, hospitals that are faith-based, all of that to talk about those kind of things. We are working with a cleaning site right now that ... All these folks have two or three jobs and so we're going to be testing them. We go into our local Piggly Wiggly, the essential workers, and that is predominantly African American young folks who many times delay accessing care. We're going to be able to bring to them and go into the community and test them as well, too. So, testing is the new way we get into the door and establish relationships. I think that is an exciting thing for us to think about.

Next slide, please. Our major issues at hand for us are supply chain resiliency. That is still an issue as we broaden out into the communities and be able to keep our staff safe. It's so important. Just in the last two weeks, I was sharing with Brian that you're going to hear from, we had 50% positive turnover rate from our testing just in the last two weeks. That's been a little scary for us as our state has opened up. Phase two starting tomorrow, to be able to go open up our community more, which we all know is necessary as well, too. But the scary part of that is those that our positive tests are local McDonald's workers, they had two positive tests there, the cleaning that I mentioned, and we're high in agriculture and manufacturing here. So, those family-based folks that are members and extended family, that's where we're seeing our positives and they're predominantly symptomatic.

Then, the lack of access to rapid tests. We don't have that yet for our health center. We're working on that as well, too. I'll have to tell you, Monday, my major issue wasn't the pandemic for the first time since March the 13th. It was Tropical Storm Arthur. For those of us in Hurricane Alley, we're officially not supposed to start hurricane season until June 1, but here we were. So, one of our sites did not have power on Monday morning. Fortunately, we have generators everywhere. As I mentioned, our hotspots ... So, that means 40% of our visits are out in the parking lots and we converted our inpatient, our in-house pharmacy, to drive-through. We have to be thinking about that and we've got weather conditions.

Then, you see this in big, bold letters, our 340B continuity. We are a provider of choice in our area. That means 50% of our business is Medicare. Early on, we began 340B in the history of our organization, and if we did not have 340B, we would be not in a good shape, we would be in a bad way. 50% of our staff would be furloughed, I'm sure, and the access that we would have would be grossly cut. Having 340B continuity is an incredible means for us as health centers. Not only because of having access to medications, which is huge, having our partners like Direct Relief that just bridge the gaps that we need to do in medications and equipment. But 340B continuity is a major, major issue for us. I could go on but look, we want to hear from Brian. So, thank you guys so much. We appreciate all the good work that everyone is doing.



Ron Yee, MD, MBA, FAAFP:

Great. Thank you, Kim, and thanks for sharing your reinstatement program here. Next, we'll move to Brian Toomey, CEO at Piedmont Health Services, Brian?

Brian Toomey, MSW:

Thank you. So, first, I want to thank my friend, my colleague, Kim. Fourteen years ago, she was talking about telehealth, so she was a visionary before all of our times. Second thing I want to say is, start with, gosh I miss my friends. I miss being at the conferences with NACHC. It's good to do it this way, but I miss everybody as well. This whole process has been one where the experience has been an experience in humility and gratitude for what we have. I'm humbled by what I see everybody doing, as well as hearing what we're doing. We'll just talk about us, but I know everybody's doing some incredible work around our state, let alone our country. So, we'll talk about what we did to begin with quickly, then where we are now.

We immediately, again, we wanted to make sure we still had access that would continue. This was 11 weeks ago. It's hard, sometimes I think it's 11 years ago. We started through telephone first and then telehealth. We're still doing some telephone work, but mostly telehealth. Medical, behavioral health, dental, and we're doing in-person pharmacy primarily with delivery of pharmacy pieces. We could quickly move over to testing, and you've heard a lot of testing experience, and Kim's was much like ours in lots of ways. Our first four weeks we set up four drive-through places and in the first four weeks we only did 149 tests and we only had two positives. At that point we thought, "Hey, you know, we're pretty lucky." Little do we know that was a mistake to think that way because the next week we did 90 tests in one week and we had 51 positives. That's when we saw that big jump in the curve. It was up high for a couple weeks and now we're starting to see some flattening of it.

It was at that point that we knew we had some problems. For us, in our area, our service area goes ... Is a seven county service area that goes from the Virginia border down through a county called Lee County and it encompasses everything from manufacturing to universities to agriculture and meat processing plants. Our testing now, through the end of last week, I'm sorry, the beginning of this week, we've done 1260 tests and we had 387 positives. That included one big community event we did at one of the meat processing plants in a town called Siler City. We just got a call earlier today; we're now doing a community event that will include meat processing as well as agricultural workers and people in the community in Lee County. We anticipate having somewhere between 400 and 600 people be at that testing that we will do in partnership with the health departments, the North Carolina Department of Health and Human Services, Agriculture, Labor, and most importantly, North Carolina National Guard. They are the ones that are actually doing the tests. The tests we're getting are actually from LabCorp who's been a significant partner for us.

This is also being done in conjunction with the North Carolina Growers Association. Kim and I talked a little bit, the growing season has now really come into full swing here in North Carolina with migrant workers who are coming to our state. It's clear that there's been an uptick from that piece and we're working with the Growers Association to test people when they come into the Growers Association where they are processed and gone out to the different farms.

But, in addition to that, we actually just got off a call yesterday with our friends in Texas, José Camacho. We're trying to arrange how we can also do some testing, because most of the farm workers that come

here come out of Laredo, but how can we start to do some testing there. Give people PPE on the buses, come here, two days later they'll get off the bus, test them, and we know where they're going to be on a farm for the next two weeks. Then we can actually make sure that they're at least quarantined if they need to be, at that farm, if they're all together. Then, make sure that if there are any illnesses that that outbreak stays contained to that farm; it doesn't go up that migrant stream which would head north from here.

So, we're pretty excited about that process and the partnerships that we've created from all that piece. The other thing I want to talk a little bit about is, again, what we're trying to do all long, as all of us, is ensuring access. So, let's talk about all the things that Kim talked about. Everybody's got their committees and doing all those things and they're very, very important. You can't communicate enough because it's just so upsetting for people to think about where they are. So, communicate, communicate, communicate, there's not enough of that to be done. So, keep going with that piece.

What we find ourselves in is, when we started as health centers, 1965 was all about access to care. We wanted to make sure there was access to care. We wanted to make sure we addressed all the barriers to care. Now we're in this different situation for all of us, which is we want to make sure there's access actually with barriers. It's just making sure that the barriers to care are the ones that are keeping us safe, not keeping people away from care. That's probably one of the big significant changes that we see and how we're going to do this. We see ourselves very much like what we think, if you look at the Walmarts of the world, the IKEAs of the world, versus other places that are just brick and mortars, we see ourselves as being brick and mortar and virtual and technology-based. In doing that, again, we have to make sure there's access to care through technology.

The other piece about the technology is we've always, as health centers, been concerned about race, ethnicity, language, all those kinds of barriers. The new barriers are going to be around ... Transportation also is always a barrier and the new transportation for us is the internet highway. How do we make sure that people that are on that highway get access to care, either the providers of care or the people who are trying to get care to, that they not only have access to care, but they have the right vehicles known as the right technology and equipment in their own homes to be able to access care.

I know my age, it's not young, and in my household, whenever our son who's 30-something comes home, he's our IT department. How do we make sure the IT departments for everybody who are of a certain age or a certain talent really are accessible? Not only when kids show up at home for people to get access to their health care. But those are the big issues that we're seeing going forward here now. We're seeing, still, that testing is being a big issue. And then, obviously HRSA's on the call, so we think about the new access points. Are the new access points brick and mortar? Are the new access points dollars that we can use to get access to people in their homes and in their communities?

When you think about the dollars spent on buildings, can we spend less dollars, in lots of ways, for people to get access so that we can get in touch with people who don't have to drive to us by a physical vehicle or drive to us through the internet highway. So, those are some of the things that we're looking at. We want to make sure that we are the IKEAs and Walmarts with the curbside deliveries and virtual deliveries and brick and mortar and staff and that we're not being left behind in this whole process. So, let me stop there and I'd be glad to answer any question people might have.

Ron Yee, MD, MBA, FAAFP:

Great. Thank you, Kim and Brian, from the front lines. Appreciate all the work you've done and are doing. We have a few minutes. Ellen, we can go to some questions for the group, if you could start those off and address them to the designated person.

Ellen Robinson, MHS, PMP:

Thank you, I've usually had a lot of great comments and questions. The first one is for CDC. We still do not have enough testing; does it mean we are not prepared to provide care for non-COVID-19 clinical care?

Ron Yee, MD, MBA, FAAFP:

Did we have Dr. Koonin or Dr. Thompson there? Yes, go ahead.

Rear Admiral Betsy Thompson, MD:

Yes, this is Betsy. That's very hard to answer without more specifics. I think, at least, correct me if I'm wrong, but if that individual could send a message and we can probably help to triage it better. Testing is critical, but if you look at the guidance, it's not ... It really depends on the situation that you're referring to. If it's a community health center testing, for some individuals would absolutely be recommended, for many, it's screening for symptoms and fever. Lisa, do you have anything, if you're still, do you have anything to add or suggestions?

Dr. Lisa Koonin:

Yeah, thanks. The other thing to consider is what the background ... The transmission is going on in the community at large. Not just the center, but in the community. Local public health should be able to help you determine that. Again, these are general guidelines. These are ones just to guide decision making, but you have to have the specifics from your local area to really make those decisions.

Ron Yee, MD, MBA, FAAFP:

Great. Thanks, Drs. Thompson and Koonin. Ellen?

Ellen Robinson, MHS, PMP:

Kim, we have a couple of questions and comments for you. I'm hoping that you could send us some of these policies so we can post. People are interested in things like what kind of generators were used and they'd like to see your leave policy. So, I'm hoping that you'll be able to go into more detail on that and we can post it on our FAQs.

There are some other questions mostly around how are you handling specific exams such as physical exams and annual physicals. How are you handling the Medicaid annual physicals?

Kim Schwartz, MA:

Yes, I'll share all the policies we have. I'll send this on to Cheryl Modica so she can have everything we have. Remember, those are temporary policies and not as pretty as we normally would do, but are all board approved. But, yes.

So one of the things that we had to do right away, we did this within I think March the 16th or 17th, we literally built a wall to be able to do... We have an outside entrance places in two of our clinics, and then we were able to isolate. I think having those funding that's available and even getting some more guidance from our state associations and technical help on what architectural things can help us in that to make them more secure would be helpful. But that's one of the things we did.

And also, I think getting the word out. I didn't even talk about the delayers of care components that are on there. I know I've seen recently the Kaiser report that talked about how everyone is delaying access to the care because they're scared. They're scared to go to the emergency room. They're scared of the hospitals. And of course, that translates into primary care as well, too. I didn't even get to touch on, we have a huge campaign going on regarding outreach, and public relations, and targeted Facebook and website, and Twitter and every way. As Brian mentioned, our access is social media, and that it's safe out there, and how to get us and not to delay those kind of care. I think getting even more help on not having to reinvent wheels on some of these things are the places that we need to strengthen that as well, too.

Ellen Robinson, MHS, PMP:

Thanks. I think we have time for one more question. Brian, this is for you. How are you tracing and case managing those who test positive, but are not registered patients in your drive-through testing sites?

Brian Toomey, MSW:

If we're testing them, we're registering them, and in our state, it's the County Health Department we notify. The County Health Department is notified of every positive. They do the tracking of the patients and for the official state response, and then we have contact with them. So, we will be calling them. We call them up every other day. That patient is getting a call every day either from us and/or the health department to see how they're doing.

And then our state just got a contract given out to do a tracing program, a much more robust contact tracing program. The tracking is the first piece, and then the tracing program, it should be starting sometime in the next month I think it said. For us, it's Community Care of North Carolina in the AHEC program have that contract and they're just about to roll that out here. We see it as critical for all the reasons that everybody thinks, because that's how we're going to contain the spread of this virus.

Ellen Robinson, MHS, PMP:

Thank you.

Ron Yee, MD, MBA, FAAFP:

All right. Thank you, Ellen. Appreciate everyone's feedback, getting to some of the questions. And I think, Brian, I appreciate you sharing what you did. And it's so critical that we have that relationship with public health and the health centers. And that is a great combination of doing testing, but then they are doing the contact tracing and following up on those and I think that's the way that it's outlined. So I appreciate that and a great example of that partnership and collaboration amongst the two.

Ron Yee, MD, MBA, FAAFP:

So in the last couple of minutes we have, if you do have any topics you want us to cover in the upcoming webinars, please put those in your chat function. We are having other NACHC divisions involved with these webinars going forward every two weeks, so you can anticipate that. Again, I want to thank



everyone for joining us, and especially I want to thank our federal partners, Dr. Koonin and Thompson from the CDC, Jim Macrae, from the Bureau, and NACHC President and CEO, Tom Van Coverden. And a special thank you to the great insights from the front lines, Kim Schwartz and Brian Toomey, for your great experience, and thank you for being on the front lines and managing our staff and communities so well.

Ron Yee, MD, MBA, FAAFP:

The recording, transcript, and slides and supporting documents that we mentioned multiple times, you can either get those under the resource tab on the bottom left corner of the screen and we will also place those on the NACHC website. We'll be back in two weeks on Thursday, June 4th at 1:00 PM Eastern time, and we'll continue addressing Reopening - What does that look like on the front lines of primary care in community health centers? We just wanted to finally say on behalf of NACHC, our Board, Tom Van Coverden, as our CEO, and our staff, is that we are with you, behind you, trying to get things funded, but also being with you on the front lines operationally and clinically. So just want to let you know, we're with you, and you all stay safe and healthy, and we'll see you back in two weeks. Take care everyone and thank you again to all of our speakers.