Rachel Gonzales-Hanson (00:00):

Good morning or good afternoon, depending on where you are joining us from. My name is Rachel Gonzales-Hanson, and it is a privilege to serve as the senior vice president of our Western operations for the National Association of Community Health Centers. Thank you for joining us today. Before we begin the program, NACHC leadership would like to say a few words. And at this time, it is my pleasure to introduce NACHC President and CEO, Tom Van Coverden. Tom.

Tom Van Coverden (00:30):

Rachel, thank you very much. And I would add, for those who don't know Rachel, she ran a very effective health center program in Texas and served as the national president for the NACHC Organization. And Rachel, your leadership over those, all these years has been really incredible, and I thank you. Let me just say that, I would also like to say hello on behalf of our current chair, a woman who is busy, I'm sorry, tied up in meetings with the government, Lathran Woodard, but who asks please to extend her greetings and thanks to all those on the phone call. I know we are all deeply, deeply concerned, and NACHC has released a statement regarding the senseless and horrific killing of George Floyd.

Tom Van Coverden (01:19):

And I would like to call upon our executive vice president for communications and chief diversity officer, and a long, long time employee of the National Association of Community Health Centers, Claudia Gibson, Claudia, just to talk a little bit about our response to that, and then I will follow up talking about what we're doing to fight for additional funding. So again, Claudia, we would be lost without you and your services. And I am introducing you my dear.

Claudia Gibson (01:51):

Thank you Tom, and stop telling people how long I've been working in the movement. Just by way, let me just say that we're all very, very, very moved and distressed. I've talked to many of you around the country, and I've been talking to staff of all races, colors, and creeds, and trying to give my perspective. And most importantly, listening to them, particularly our younger folks. I was born and raised in DC. I'm a child of the '50s and '60s, and I witnessed all of the protests and I was a part of a lot of the protests, et cetera. And as we speak, my daughter in Boston, I can't get in touch with her, but I think she's in the middle of a lot of the peaceful protests right now. So I think I've gotten a lot of feedback on the statement, and we certainly at NACHC recognize it's just a statement.

Claudia Gibson (02:46):

So I wanted just to relay to folks what I've said to staff and some of the members that have called me, and that is first of all, let's recognize that our model is a very good example of community partnership. But we do have a lot of ways to go, and a lot of work to do in that area. But I do think that we can be part of the change, but change has to start at home. And I've had a lot of conversations with our chair of the board, Lathran, over the last week or two. And even starting with our previous chair, immediate past chair, Jim Luisi, it's interesting. He did a lot of listening to us while he was in office. And we got a lot of feedback from the field in the areas of NACHC's own processes and structures and things.

Claudia Gibson (03:39):

And so we're working on a lot of recommendations that came out of that, that have to do with diversity inclusivity. And that's not only with NACHC's staff, but it's about leadership, and it's also about our membership. And hopefully in the next few months, you'll see some forward movement on that. But I'd like to also challenge, and I don't know if they're board members on the call, but I'd like to challenge our board members as well, their role in all of this in terms of change is to beef up their efforts in the communities and start with the local leaders. Our story is perfect as an example of what's happening and what needs to be done, and I ask that health centers and our primary care associations, also look at their structures and their level of inclusivity in their processes to make sure that we are attracting and making people feel comfortable with input from all types of people in terms of what we are doing, what we're not doing, and to make people feel welcome into our movement.

Claudia Gibson (04:45):

I can assure you that Lathran is on top of things with us, she's been very encouraging with us. And we too at NACHC, I want you to know we're going through a process. We're looking inward in terms of our own policies, our staff, I think our staff right now, and I don't believe in just numbers, our staff is very balanced in terms of ethnicities and race, age, gender, sexual orientation, but that's not enough. We recognize that and we're looking at ways we can strengthen our processes to make sure there's opportunities for more and more people, and particularly the younger staff that's coming in. So with that, I guess I want to just end it, Tom, by saying that we did these listening tours a year or so ago, but we are still open, very much open to suggestions from our primary care association partners, from our membership, from board members, staff at health centers, leadership at health centers, on ways we can improve NACHC to make more people feel comfortable, more inclusive with us.

Claudia Gibson (05:56):

And it's going to a challenge of course this year as we go into doing virtual conferences and things, but it presents opportunities. And I just think that we're strong as an organization and as a movement, and I'm very proud to still be representing and working with all of you. And I want to thank you, and hang in there, this is a tough time for all of us.

Tom Van Coverden (06:19):

Claudia, thank you so much. And for your very valuable contribution, ongoing, including your work with the press at all levels with your staff and Amy, and key articles that you've gotten on talking about this inequality just building a little bit. And one of the things we are stressing in a big way and advancing our own policy, public policy agenda, is what you said, Claudia, that health centers indeed, this whole movement was founded upon a solution during the civil rights movement. And it will let us never, never forget that. And we're talking certainly about the black population of America, but also the migrant farm workers, and Latino populations, we're talking about the Asian populations currently working throughout the country, and of course native Americans.

Tom Van Coverden (07:10):

So we are very much concerned in that, and I think holding it forward, and people well outside of NACHC, have said that you are one of the most successful programs in the nation that has ever been created. And maybe most importantly was how you have integrated, and how you have involved those most left out and forgotten, the vast majority being minorities, to create a program and create it in a way, starting with community boards, in the patients themselves having a voice, recruiting people from the movement, the recruiting of physicians that are highly sensitive, and themselves of color, and having

the expertise and deep commitment too, such that in dealing with any number of situations or disease, the school based program, so the HIV program, immunizations, behavioral health, now the senior programs. Again, community health centers have led by involving everybody in setting priorities, in developing and shaping programs and implementing those programs. And you should never forget that.

Tom Van Coverden (08:23):

Again, those are other people in foundations, in the Congress, and a number of past presidents. And so my friends, I see that going forward, it's not the only thing, but when people are looking at, okay, so now that we've all expressed concern, what is it that we're doing to make a difference? And how do we get people more involved in the processes? And again, community health centers do that. On a very quick note, I would like to, on the funding, we continue to fight for you on the funding, including the discussion to implement much of what we're talking about today. Let me just say that, we've currently managed to produce about $6 billion in additional funding, and there's probably an additional 20 on top of that with the provider payment protection, et cetera, that is currently being looked at to get allocated.

Tom Van Coverden (09:12):

I think is when if you know in the current legislation at the house pass, there's an additional 7.6 billion exclusively targeted for community health centers to expand the COVID testing and treatment programs. In addition to that, we are currently working, and letters have been sent, you should have copies in the mail, about the additional almost 198 billion to be state correctly in the public health and social services emergency fund, that has not yet been allocated to Medicaid providers, of which we are a large one. Again, NACHC with 15 other organizations have signed a strong letter, which has gone from the chairman of all the Democrat and Republican house and Senate to the secretary, saying it's time to get the money out into the street and to the people doing the work.

Tom Van Coverden (10:11):

Please know that we are working very aggressively to get that amount of money, a good portion of which will go to community health centers. As well as passage of the house legislation that was passed with a 7.6. Let me say, that still leaves us about $70 billion, or close enough to it that we'll be fighting for, to have included this year, to include the five-year re-authorization, additional funding for the infrastructure and workforce related programs, which gets into including dental, and what you're talking about today. So NACHC will continue with everything it has to be fighting a full fledged for that, and I feel more energized than ever. And I hope it speaks for all of us, especially when we move from the situation, again, that happened over the last week, and it's been happening for some time, how we deal with those minorities that are most heavily affected in the nation.

Tom Van Coverden (11:10):

One area we can help a lot is by improving the healthcare, creating jobs, and building the infrastructure in those communities. With that Rachel, I thank you and thank all of you for your support, and you're going to be with us. We're going to need a lot of grassroots effort to finalize and to get this achieved, please stay with us on it, and we are winning.

Rachel Gonzales-Hanson (11:32):

Thank you so much Tom and Claudia, your leadership along with that of NACHC's Board Chair, Lathran Woodard, will get us through these very exceptionally challenging times. Your messages are right on,

there are a reminder that we all have a role to play in this world, a responsibility to make it a better place. Through all of this, we must continue our unwavering efforts to fulfill the mission of the health center movement, health equity for all. As we begin the program, let's get some housekeeping items out of the way. If you're having any technical difficulties, click on the request support button at the bottom of the screen. For those joining via internet, some of today's speakers have content slides. The recording transcript and the slides will be posted on NACHC's website after the webinar. If you have a question during the panelist presentations, or during the formal Q&A at the end, please enter it in the Q&A with the speakers area, and include whom you're directing your question.

Rachel Gonzales-Hanson (12:34):

We will try to group the questions around topics or themes, to make our Q&A time more efficient. Questions that we are not able to get to, will be added to NACHC's website in the COVID-19 page. If you wish to chat with other participants, and I see some are now, or communicate with a NACHC staff during the call, please use the chat feature. And lastly, and just as important, we would like to hear your ideas about other future topics. If you have any of those to recommend, please also enter them into the chat feature. Let's get started today. Since March, NACHC has hosted the flattening the curve webinar series to provide the latest updates from national and federal partners, as well as insights into what health centers were experiencing as they weather the COVID crisis. Today, while the crisis continues, health centers are working on reopening their doors, but we must acknowledge two things.

Rachel Gonzales-Hanson (13:34):

First of all, we know how centers never really closed. Their flexibility and innovation, enable them to continue providing care in a modified way. Second, the phrase reopening the doors, means different things to different health centers. Varying factors impact each health centers efforts to reopen. For example, the status of their workforce, meaning, do they have enough staff to proceed? But also, how about the staff's well-being? It also includes the health centers financial viability, and ensuring the safety of staff and patients in facilities. And of course their ability to obtain and maintain an adequate supply of tests, PPE, and all of the other supplies needed to operate. While it remains critical for health centers to continue their focus on appropriately responding to the COVID pandemic, it is just as imperative that we look to the future. It is clear there is no going back to yesterday's normal.

Rachel Gonzales-Hanson (14:36):

This pandemic catapulted the healthcare system, and especially health centers, into the future. And health centers are now at a crossroads, do we maintain the status quo? Or do we evolve and innovate to continue leading in the delivery of primary healthcare? This is our opportunity. That flexibility, brilliant innovation and transformation, health centers are using to battle COVID-19 has opened the doors in so many ways for health centers to re-imagine healthcare. Let's look at those innovative approaches as viable, efficient, and effective healthcare delivery models to shape the future of America's health centers. With that in mind, NACHC is excited to introduce a new webinar series entitled re-imagining care. This five-part summer series, will provide examples of promising practices and get into the nuts and bolts of operational practices. All the while building on the innovations necessitated by COVID-19.

Rachel Gonzales-Hanson (15:42):

Today's webinar is focused on reopening dental practices, and Dr. Donald Weaver, will be moderating the panel. Dr. Weaver is a NACHC senior advisor for clinical workforce, and has had an esteemed career

with the public health service and HRSA. He is an expert and a resource at all beings oral health and health centers. Dr. Weaver, I'm going to turn it over to you.

Dr. Donald Weaver (16:07):

Thank you very much Rachel. And on behalf of all of us, for all of you out there on the front lines, we want you to know we're daily in awe of what you are doing with care and showing your compassion to improve the health in your communities during this pandemic. Thank you seems like not enough to say, but we want you to know how much you're very much appreciated out there. Rachel, with health equity and social justices as cornerstones of our health center movement, now is the perfect time to reimagine. Imagine again, rethink, in order to change or improve ways to achieve optimal health for all. As Rachel mentioned, we will have some time at the end of this presentation to answer some of the questions, and ways to get those answers after the webinar if time does not permit answering all of the questions which we anticipated.

Dr. Donald Weaver (16:58):

Well, we want to acknowledge a group of partners who have a variety of resources, which you may find helpful. Some of them are obvious, our federal partners, HRSA, both the Bureau of Primary Health Care and the Bureau of Health Workforce, the Centers for Disease Control and Prevention. I want to add one here, and although I know this session is on reopening dental practices, please take advantage of the resources available through The Substance Abuse and Mental Health Services Administration, the mental health and behavioral health implications of both the pandemic and the tragic situation that we're in, in this nation right now in addressing racism, is going to be high, and we need to take advantage of all those resources. Our cooperative agreement partner, the National Network for Oral Health Access, the DentaQuest Partnership for Oral Health Advancement, the Oral Health Progress and Equity Network, State Dental Directors and Primary Care Associations, Health Center Controlled Networks, and what we're going to hear from now, health centers from across the country.

Dr. Donald Weaver (17:58):

I hope the message is loud and clear. We're learning from, and here for each other, as we reimagine. No one has all of the answers, but when we can share, we can learn a lot from each other. And most importantly, the beneficiaries are the populations and people that we're privileged to serve. Since you have bios in the slide deck, I will be introducing people with one liner, so we can maximize the time that they have to present to you and get to your questions. And our first presenter is Isaac Zeckel. I did say that wrong Isaac, it's Isaac Zeckel, Chief Dental Officer at HealthLinc in Indiana. So Isaac, I'll turn it over to you.

Isaac Zeckel (18:37):

Great. Thank you very much Dr. Weaver for that introduction, and thanks to NACHC for having me available to share HealthLinc's journey to reopening our dental practices. Next slide please. And again, next slide. One more. Okay. Thank you so much. So I represent HealthLinc. We are a health center in Northwest Indiana, we had the privilege to serve 40,000 patients last year across 15 sites. Five of the sites provide dental services. We have a diverse demographic that we serve. Next slide please. And as many of you have also experienced, our journey through this time of much uncertainty started very quickly and resumed very quickly. I'm sharing with you a graph of basic encounters that my dental providers were achieving, and a precipitous decline in April.

Isaac Zeckel (20:00):

And so like many dental programs, we were able to repurpose our staff to support our medical colleagues, while we were still able to do our part in keeping the emergency rooms free of dental emergencies. This time, separated many of our staff that were used to working very closely together, which allowed us an opportunity to implement a new system of staying connected in a very uncertain and rapidly changing time. Next slide please. So we took this opportunity where we had time to innovate a new system of staying connected, and that system of staying connected is part of Microsoft Office or Microsoft 365. And Teams is a communication and collaboration platform. And we use this to change the way that we're able to stay connected. Before, many of my programmatic changes involved telephonic meetings, many emails, policies and procedures for which I've shared with you all for today, one-on-one coaching.

Isaac Zeckel (21:19):

And then one of the most difficult to fix is that interoffice communication where much of the silo-ing at our sites would occur. So Teams really radically changed that. I could record my team meetings, record for people that weren't able to be around, either were off taking care of loved ones or were unable to be there on that day. I was able to collaborate with work groups to work on projects that we would have not been able to do unless we were in person. And email became much smaller part of my communication with my team. Finally, mini surveys, I could check to make sure that my staff understood what I was trying to communicate with surveys and quizzes, and so I would have records of any ambiguity that maybe surrounding those tasks and things that I'm asking to do. Because this communication tool allowed me to instantaneously connect with my staff. And really, this tool helped me, now during this time, overcome the three main challenges in restarting our dental services.

Isaac Zeckel (22:45):

Next slide, please, I'd like to talk with you about the first main challenge, and things that we've learned along the way as we've restarted our practice. The staff really are unfamiliar with all the new PPE requirements and all the additional infection control protocols. Many of the staff have never worn N95 masks, they've never worn face shields, and many of these things before are new to learn. The N95, you have to keep in mind that not all N95 fit people the same. And what we found was, when we first fit tested everybody, people were satisfied, but as they've restarted services, they're finding that it interferes with their glasses, it may not fit as well as they had thought, or even our supply lines have uncertainty if they're going to be able to receive the same mask. So that's a really important part to keep track of, if I was restarting my program again, making sure we knew which staff had a mask that fit, so we could deliver that to them in a timely manner to make sure they're protected.

Isaac Zeckel (24:09):

In addition, the staff really will have trouble getting used to all this. It's very uncomfortable, it's very difficult to breathe, it's much harder than it was before. So these are all things that, when you restart, you have to take in consideration both environmentally and with the schedule. So if I were going to give some pointers, I would suggest identifying a suitable area for putting on and taking off the PPE. That's an area kind of set aside where you can store the PPE, you can have your sanitizers, your alcohol hand sanitizer, masks, gloves, the whole 9-yards set up here. And that's what that image depicts. And then, the staff really need to practice a lot. It's foreign, and the more they practice with each other, the better they'll get at it. And then furthermore, I required that all my staff demonstrated over video conference

with me directly to verify that it's fitting correctly, that they're able to put it on and take it off without contaminating each other. And so I was able to achieve that with utilizing Teams.

Isaac Zeckel (25:36):

And then finally, we want to minimize the movement of staff and materials from the clinical area to the non-clinical area. We want to keep everything separated. And we wrote policies and procedures for that, as well as putting up simple signs that say, stop. Next slide please. Unless the staff get used to wearing all this additional protective equipment, there's going to be a timeframe where it's going to take some time. They won't be as efficient as they were before, and they may have some slip ups. So the way we tackle the schedule and way that I thought worked well is, we created a framework for the procedures. Stratified the procedures and higher aerosol or higher risk, as well as a priority. So a dental work group stratified all the procedures into these categories, which helped us kind of set the stage for what we're going to do when.

Isaac Zeckel (26:50):

Next slide please. So this is a representation of what I've been sharing with my staff, and it allowed us to kind of slowly ramp up as the staff were getting more used to everything, all the changes that are actually constantly occurring, the CDC is updating its recommendations every day, we're running into various staff concerns that we were addressing. So this kind of ability to provide priority services that have a lower risk at the beginning will really help reduce the risk. Next slide please. And as we restarted services, it's very apparent that we could not maintain a percent of our productivity like we experienced in April. So we sat down with the CFO to set goals for the staff. And we were very honest and open about what it's going to take to return us to financial sustainability. And so I was very transparent in talking with the staff and say, "Okay, this is our goal. In June, we have to get to 50%. In July, we have to get to 80%. And if we can work together, I think we can get there."

Isaac Zeckel (28:23):

And staff are just one component, we really have to reassure the patients. The patients are nervous about coming back into the office. We were able to create a video, that the link is below, but basically it shows the patients what they're going to expect when they come in. There's going to be a lot of questioning. They're going to get your temperature taken. There's not going to be magazines in the waiting room. So it helps bring the anxiety level down with the patients, so understand what's going to be happening and what might look different when they come in. And then you're not ever going to get anywhere without the staff onboard. So like I've mentioned previously is, staying in touch with the staff. And our communication tools made that much easier, especially since everybody's been relegated different parts of the state during this time. And addressing their concerns and doing everything you can to rectify problems that may come up. And then once you get everybody on board, you've addressed the concerns, it's going to be a constant cycle of modifying the templates and being very specific about what procedures are going to be done, when, how much time are we going to be allowed to disinfect, how's that all going to work. So the more specific you can be with developing your templates and workflows, the better.

Isaac Zeckel (30:02):

And then keep the staff informed about what the successes are. How are we progressing towards the 50 and 80% goal that we've outlined? So if one of these components falls down, or we will struggle to maintain financial sustainability. So next slide please. And finally looking ahead, we've invested very

heavily in Teams, in that platform of communication with our staff. And just because we're starting to reopen our dental offices, doesn't mean we're going to let that fall by the wayside. It just was such an effective way of staying in touch with everybody. And part of working in a collaborative practice with our medical partners, our pharmacists, podiatrists, optometrist, is being able to communicate with each other. And I believe this platform helps us achieve that. And some of the ideas that we are looking into is getting our patients vaccinated in the dental laboratory, where the dental staff would message the medical assistant electronically and say, "We need a vaccine." The dentists would talk with the parents about getting HPV. The medical assistant would come down and immunize the patient in the dental chair the same day. How convenient could that be?

Isaac Zeckel (31:37):

And that could work for flu or even COVID-19, when that that vaccine comes one day, hopefully sooner than later. And then working with the warm handoffs between the medical and the dental, well child checks, pregnant women, high-risk diabetics. Those are all opportunities that this communication platform we're looking to invest in. So with that, I will turn it back over to Dr. Weaver, and I really appreciate your time. Thank you very much.

Dr. Donald Weaver (32:11):

Isaac, thank you so much. We're going to take ourselves across the country to Washington and Oregon, and Steve Davis, who's the Chief Dental Officer at Yakima Valley Farm Workers Clinic. Steve, we'll turn it over to you.

Steve Davis (32:24):

Thanks Dr. Weaver. Also thanks to NACHC for reaching out to me. Dr. Zeckel gave a great presentation. I think you're going to see a little bit of kind of overlap, which is telling that, I think we're all in kind of the same situation nationwide, as we're looking at these things and moving forward. Next slide please. Great. So a little bit about the Yakima Valley Farm Workers Clinic. I'm going to call them Farm Workers from here on, because it is kind of wordy to go through the whole thing. So we are in the Pacific Northwest. I think when most of us, at least I'm from the Midwest, when I thought of the Pacific Northwest, before I moved out here, I thought of Seattle, but little geography lesson about this area of the United States is that there is a big mountain range called the Cascade.

Steve Davis (33:09):

It goes right through Washington and portion of Oregon, and what it does, it divides the state into a couple of different climates. And so where we are on the East side of the state is a high plains desert. And so fortunately, we have a large river called the Columbia that runs through our portion of the state and allows us to water all of our land. And so we have rich volcanic soil here, and it's a great place to grow things, as you know, apples, other produce, and hops, which are great too for beer making throughout the United States. So a little bit about the Farm Workers. We do have 24 medical locations. We have 14 dental locations, pretty big staff, 33 dentists, 13 dental residents. We run both an AGD and a P residency. We're up to 149 operatories right now. We have mobile units. Dental specific has about 55,000 unique patients. And year before last, we saw 141,000 visits. System-wide, we have about 166,000 active patients, and usually we do over 700,000 visits a year. Our population is mostly Hispanic, about 65%, and more than 40% of our patients speak something other than English. So, all right, let's go to the next slide please.

Steve Davis (34:30):

Great. Thank you. I think this will be familiar to a lot of us, and I want to kind of progress through things that happen as we started to see the COVID-19 number take foothold. Initially, we were just doing some screening for traveling out of the country, and as I think we have all of that rapidly changed into screening or multiple different questions, and as we've progressed through the last few months, those questions have doubled in size. And so currently we're doing this in all of our sites, we're just screening all entrances for patients, we're screening over the phone, we're screening during our virtual visits. We're also screening staff and asking them that they test, that there is some data there. So early on, we made sure that we put in some clear barriers for our direct front facing staff, came up with a policy to talk about universal masking for all staff, keeping in mind that we needed to monitor our PPE.

Steve Davis (35:28):

And then we really had to move rapidly, both in medical and dental, to provide a way to give access to our patients, since there was kind of an inability for them to come in, in person. And so on the 6th of April, we started indulgence in Washington, and April 10th we did that in Oregon. So off to the right, you'll see there as I have a very active IS department and some team members that worked on creating new smart phrases, or kind of basically text notes that are embedded in our Epic Software. So we use something called Wisdom. And then we roll that out to all the clinics, and we're still utilizing them even as we go into these kind of next phases of reopening. Throughout the last few months, we've remained open for emergencies, we're always on for community emergencies. We definitely are open for our patients of record. And actually we continue to do our GA services for pediatrics.

Steve Davis (36:26):

We recognized that there was going to be a significant risk if we allow those patients to wait until after the epidemic started to settle down. And so we actually boosted those services and provided more access. It's actually helped us get through some of the backlog that we had. Within our Epic EDR, we created a work queue that would help track those more at risk patients throughout the time, and now that we're getting closer to resuming more services, we're utilizing those work queues to get back in those patients specifically since they have more pressing needs. And then to give an idea about the impact that we've had the last few months, typically we see about 10,000 dental visits every month, a little bit more, a very scrappy year. Throughout the last two months, we've been closer to that thousand mark, but I will say kind of proudly that, almost 5% of those visits were teledentistry visits. And so it's been able to get us some access to patients, screen them before they physically showed up at the clinic, and assess their needs without having to either put staff or the patient at risk themselves.

Steve Davis (37:36):

Next slide. Can you all hear me? Am I not speaking loud enough? I'll try and get closer to my microphone, I apologize. So let's talk about phase one, because we are straddling two different states. These things happen at different times. And so in Oregon, on the fourth we were allowed to reopen to really elective care. And on the 18th up here in Washington, we can do the same as well. So when we did the opening, we maintained our screening. We also had repurposed our mobile units at a number of our sites to allow outside COVID testing. And so when patients present at the door and they were potentially symptomatic, we actually cannot move them through that at that line and get them COVID test. And so our recommendation for this first kind of phase of reopening was that we would exclude our at risk patients, which means anybody who's 65 and over, or those that were CDC or ADA at risk

patients. We continue to utilize teledentistry to manage their needs, but they could be brought in if it was necessary.

Steve Davis (38:44):

The other thing we really emphasized, I think that you'll see this elsewhere in some other guidelines is that, we want to reduce the number of non-patients coming in with patients that are coming to actual clinical care. And so trying to reduce the number of parents to one, and no siblings. And then whenever one is entering the building, we would ask them to either mask up, and when we call them, ahead of time we would ask them to bring a mask with them, and then we make sure that they're masked up when they're in our facility. One thing I didn't mention before is that, during the turndown, we actually had decided to rotate our dental staff on half on half on, and two week rotations. First to keep them safe, and reduce exposure, and then also manage the fact that we had a reduced demand for patient care. And so we also reduced the physical staffing level, which the DA systems that we're working them to a smaller thing. And then repurpose a lot of the staff members to work on the front lines with screening outside, helping with our mobile unit screening, and utilize them wherever we could.

Steve Davis (39:53):

And as you can imagine, because we had a relatively large dental staff, we did have to put some employees on a temporary leave, include our hygienists, but I'm hoping to get them back here within a week or so. To get back to the first phase there, no hygiene visits for that which is expected. We're going to bring services back based on the demand, which we are seeing slowly increase our time here. And we really think about doing like half schedules. And so one thing that a health scheduled does is allows us to create some extra physical space between patients, because we can utilize every other chair. Waiting rooms, we reduced the number of chairs out there, then we put everything six feet apart.

Steve Davis (40:36):

And at this point, we're actually saying that almost any procedure can be scheduled, no implants, we definitely wanted to focus on our phase one at a child recalls, and taking care of that population, and their restorative needs, and then getting through some of our patients that were more symptomatic. And so those patients that were waiting to have their endo completed or needed a denture delivered because they were having problems eating. One thing we also did in this phase one, which was a little bit unique is that, we had asked for all patients that were coming back for aerosolizing procedures to actually have a COVID test before their visits. So we would actually have the dentist put in an order for the COVID test, and then those patients would be moved through our external mobile units, or other sites outside, and they'd have the COVID test done, and then within three days it would end up in our Epic record.

Steve Davis (41:33):

We contact those patients, and kind of verify that with them and then get them back for service. So there was a pretty severe amount of workflow that had to be developed behind the scenes around that. So I'm happy that that is in place. It's not without hiccups though, because there have been issues where sometimes those tests take more than three days to come back. And so I think as we move forward into the next phase, which is phase two, hopefully as we kind of change some of those requirements, it'll give us a little more flexibility. Next slide please. And so phase two. So what I want to do here is highlight the changes, and then also kind of mention that, chart I have on the lower right hand side, that directs more stuff. And so phase two, which is where we are now and started this week, is that we are going to

go ahead and return back our hygiene visits. But at this point we're asking for only hand scaling and we're not going to be using the Cavitron.

Steve Davis (42:29):

So we just want to emphasize two of things. We want to limit the amount of spite what's happening is that, for kid visits, we're going to be doing a toothbrush prophy unless we're using a prophy angle. So we do have hygienists that work within our pediatric practices, and they're going to come back and do expanded duty with those dentists. And then really getting back to a normal staffing level for one provider, but continue the rotation in and out of our clinics as we see demand increase. And then really we did not put strict restrictions on procedures as long as they're maintaining a reasonable value and level of patients coming to the practice. And then one thing we did this last week is we actually removed the requirement that we have a COVID test for every patient coming back for an aerosolizing procedure.

Steve Davis (43:16):

Given that though, I think that the previous plan, which was to do the testing, did help mitigate some risks because I found out last week that we had six positive patients that were asymptomatic that had had that COVID screening, and just told me that what we're still facing in our community, isn't always completely apparent. And then this is kind of an idea of what we're seeing here in Washington and Oregon as well too, is that at 4/30 we had 558 positive patients. By 5/26, we had 1200 positive patients in our population. And that continues to rise. And so when we have looked at reopening our practices, because they're in such diverse different environments, we've had to approach every practice a little bit uniquely. And so we still have one clinic here in Toppenish, which remains only open for emergency treatment because of the high level of patients that are testing COVID positive in this population. Next slide.

Steve Davis (44:18):

Great. Thank you. And I think that everybody's familiar with kind of the PPE guidance that's come down through the CDC. Just wanted to kind of get this as a reference for those of you that maybe are not kind of as well versed with those. I think that the dental providers have seen a lot of this, and we've learned a lot about PPE over time here. So I'm really fortunate to have a really robust quality department that works with me, that helps me kind of keep ahead of the CDC guidelines and OSHA guidelines, and make sure that we're doing things that are appropriate to protect our staff and to protect our patients. And I think the one thing that we've really focused on too is keeping an eye on our PPE. And so about a month and a half ago, we created the burn rate calculator to see what our burn rate would be for our PPE usage as we go through this, and it helped us kind of monitor what PPE we have left on hand.

Steve Davis (45:09):

And there's many reasons for that, but specifically, we want to make sure that we have adequate PPE in case we need to revert back to our previous plans in case there's an outbreak. And so both Oregon and Washington require that we have at least a two week emergency PPE on hand. And I know there's a lot of questions around in N95 reuses, some you can read about from CDC. There's some good recommendations from there. It's unfortunate in that we're in that situation, we have to worry about our supply of N95, but I think managing them appropriately, we should still be able to provide an adequate level of patient care. Next slide please. And then current next steps. And so right now we're really interested in looking at the next step in the facilities. And so there's been a lot discussion about closed operatories versus open operatories. We don't have the luxury of having all closed operatories

because the way that our clinics already built, but we do have a number of closed operatories. And so we're putting in dedicated exhaust fans to convert them into pseudo negative pressure rooms for those longer procedures that will be highly aerosolizing.

Steve Davis (46:23):

So we've also looking at our internal HVAC system, and how we can increase the Merv rating of our filters. And so there's a lot of discussion around that too, and what level is correct. So we need to find the right balance between filtering and also allowing air flow to go through those units. So we're continuing to monitor that with our facilities department. Our quality department actually has just recently purchased a, it's called an RH-N95 mask decontamination units. So it's specifically for decontamination N95s. And so that will hopefully show up today, and we're going to do some internal testing on that to make sure that it actually is working. We will not be having providers reuse others masks. We will mark each provider's mask and they will have their own mask back after it has been sterilized. So next phase, which we are probably going to look at in about two weeks, would be returning the dentist to a more normal staffing level. And then also talking about how we want to use point of care testing. So we do have Quidel's ability to do the same day testing.

Steve Davis (47:32):

So currently we're worried about the number of tests which they have available for that same day testing. And so we're going to utilize those mostly for patients that really need to be seen that day, or emergencies. And then also just to potentially screen patients that are testing symptomatic especially in the medical side, but want to go back to work. And so we can kind of verify that you are positive, you should be avoiding work. And a couple of things I didn't put on this slide. One project we had started before the COVID epidemic happened, was to embed dental hygienists on our medical side, and kind of have them provide care there too. But what we found out early on is that there were some issues of reimbursement, especially movement into our WIC department. And so that is kind of a blessing for us, because I think moving forward having them on our WIC department will probably reduce a little of the burden of those WIC patients coming over to the medical, and we can distribute the amount of patients that are being seen throughout the system and provide care that way.

Steve Davis (48:39):

I think that's about it. Next slide. Great. So let's give you a little resources there, and then just to show you how different dentistry is than it was three months ago, the level of PPE that we're now having providers wear. So there are some adjustments that happened, and so I think that as a dental community, our interest is in maintaining the safety of our staff, also to maintain the safety of our patients as they come through our system. And so I think as we move forward we're going to get a better understanding of, what are the risks out there? How do we mitigate those risks? And hopefully get some more real world data to back those steps up that we're taking. So with that, we'll move on. Thank you so much for your time. I really appreciate it.

Dr. Donald Weaver (49:32):

Thank you Steve. And I'm going to bring us back to the East Coast now with Michele Chambliss, the Director, Federal Tort Claims Act Division at HRSA. Michele.

Rachel Gonzales-Hanson (49:51):

Michele, you might need to take yourself off mute. Michele? Don, maybe we could start with a couple of the questions, before we get Michelle back on.

Dr. Donald Weaver (50:14):

I was wondering the same thing Rachel. So while we wait for Michele, I introduce you to my NACHC colleague, Phil Stringfield. Phil, do you have a question for the group while we're waiting to reconnect with Michele?

Phil Stringfield (50:30):

Awesome. Thanks so much, Don. And thank you our presenters for sharing some of that insight. We definitely got a lot of questions from the field, but want to go ahead and send it around. And this question can go for both presenters - consider around your operatory. So one of the questions, do you have an open plan dental operatories. If so, what facility modifications have you made for greater infection control? And then in addition to that, so how long do you wait for the aerosol to settle before bringing in the next patient? So a couple of workflow questions there as well.

Michele Chambliss (51:07):

Hello? I'm sorry. Can you hear me?

Dr. Donald Weaver (51:12):

We can hear you now, Michele, and then if we could have you present. And then Phil, we may ask you to repeat that question after we finished with Michele. So Michele, fire ahead.

Michele Chambliss (51:21):

Okay. Thank you Don for the introduction, and thank you NACHC for inviting me. Good morning and good afternoon. As individual states begin to resume dental care, we have heard that health centers are concerned that there is a risk to their FTCA coverage and coverage of their providers, given potential differences between states, federal and professional associations guidelines on reopening dental practices. So I put together some practical guidance as it relates to FTCA coverage, that I want health centers to consider as we take this journey together and as you reopen your dental practices. First and foremost, whatever you were planning to implement going forward, the health center must base decisions on its ability to provide a safe and secure environment for both patients and staff.

Michele Chambliss (52:22):

This is going to be a new reality for us, and we're going to have to reimagine how health centers are delivering care going forward. In order to reduce the risk of professional liability allegations regarding a breach of standard of care, health centers must carefully review state, local government regulations and guidance, as well as federal agencies and state dental association, public health department, and dental board recommendations, prior to making determinations regarding reopening and the operations of your practice going forward. I know this can be challenging, very challenging times without having a universal plan that all the nation follows, but health centers need to assess whether the care that they are providing meets the standard of care for their dental care at the health center.

Michele Chambliss (53:24):

Please note that providers get their license from the state, and you don't want to jeopardize their licenses. So they do need to adhere to the rules that govern their license as well. Documentation is key. When in doubt, document. People always ask me, "Michele, what do we document?" You will document that there is a pandemic, we are operating under whatever the guideline is and why. So you want to articulate what the state of affairs is at that time that led you to that decision. You want to also, I would recommend that you put it in a master file, that the health center can quickly submit if any litigation arises in three, four, five years down the line. You want to also revise your policies and procedures, as well as make sure, excuse me, make sure that your staff are aware of these revisions and that you're putting them in place. If you're ever audited, you want to make sure that your policy sees the procedures that govern your staff are the reality of what you're going through.

Michele Chambliss (54:48):

We got a lot of questions about, do we create specialized COVID-19 forms? I really don't advise using a separate COVID-19 form. Instead, you should be obtaining basic consent for specific treatment as you ordinarily would. You may want to expand on the current language to include risks related to the public health emergency as COVID-19 that we're experiencing today, that also will cover you from, if we do encounter public health emergencies in the future you have that language and you do not have to keep revising it. It will stand on its merit. Remember, an informed consent form by itself is insufficient to shield the medical provider from liability, and creating one specific to COVID-19 may provide a dentist with a false sense of security. Rather, an informed consent form is designed to be part of a process of obtaining patients agreement, following the explanation and discussion of why the treatment is needed, as well as the risks of an alternative to a procedure.

Michele Chambliss (56:12):

When it comes down to tele-health, including teledentistry, this is an eligible practice for FTCA coverage when services are within the health centers scope of project. At this particular time, we've gotten a lot of questions on, will there be a sunset clause related to this? Right now we'll operate in the here and the now. Remember what I said in the beginning of my talk that we're going to have to reimagine how this healthcare is delivered. And we will let you know if that provision is no longer in effect, but right now it is status quo and continue with your efforts. Health centers and providers are encouraged to consult with private counsel, and consider the purchase of private malpractice insurance when undertaking activities that may not fall within the health center's scope of project.

Michele Chambliss (57:16):

Remember when we talk about volunteers, which is something that came under the Cures Act, we're talking about volunteer providers that are licensed, certified and registered to provide clinical services. So remember, keep that in mind. And right now, you would have to put in what we call a VHP, a volunteer health professional application, to make sure that that provider is covered. There's a lot of questions also out there about non-health center patients. At this particular time, we put a particular IES determination out, which does cover you for non-health center patients, as long as you are within the scope of your H80 grant. As we continue to evolve in this process, we will keep you informed of any program updates.

Michele Chambliss (58:17):

Please go to our website for updated information. It's timely. As we get questions in, we do frequently asked questions, and post it on the website. So stay tuned for it there. And should be up for your

viewing, our health center program support line, which you can get an individual from our program from 7:00 AM to 5:30 PM, Monday through Friday. There is a link there, as well as a telephone number. That is the best way to get quick responses to the questions that you have. So at this time, I'll turn it back over to Dr. Weaver. And I thank you for your interest in HRSA's FTCA program.

Dr. Donald Weaver (59:10):

Thank you so much Michele. In the interest of time, and also knowing that a lot of people want to attend today's show, that's today with Macrae, Rachel, I'll let you wrap it up and remind people to please put your questions in the chat box or send them through the email note that we have on the slide. So Rachel, back to you.

Rachel Gonzales-Hanson (59:30):

Thank you so much. I do want to thank everybody for joining the call today. And we also want to give a special thanks to our speakers. A dear dear thanks on my part to the NACHC team for helping bring this program to fruition. It was awesome. Save the date for June 25, July 9th, July 23rd, and August the sixth, for the rest of the series. And remember to stay safe because you're very important. Have a good afternoon everyone. Thank you.