

May 1, 2020 CHC COVID-19 Task Force Meeting

Agenda

<https://ncchca.zoom.us/j/702373706>

Meeting ID: 702 373 706

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Task Force Group: All Health center CEOs are invited, as well as representatives from different disciplines within health center including finance, operations, medical, behavioral health, and Human Resources

Welcome, Logistics, Agenda Review

Partner Presentations/Discussions

CCNC/AHEC: Efforts to Support COVID-19 & Contact Tracing Initiative

Tom Wroth, MD, MPH

A few weeks to get the initial roll out right. CCNC would like to get feedback from health centers.

Context: Governor's plan to reopen North Carolina: Testing, tracing and trending. Use data points to open up parts of the economy, including primary care practices.

Increased testing and effective testing will lead to better case investigation and tracing effort.

Approach:

Partnership with state as the lead: Dr. Tilson, DPH. LHD as the current infrastructure that does investigation and contact tracing. Part of CCNC and AHEC's role is to effectively and rapidly build on that infrastructure. Use this situation to build better infrastructure to respond to these emergencies.

CCNC and AHEC partnered and put in a proposal to play a role in rapid hiring of contact tracers. With our partnership with DPH, LHDs, and provider practices, to deploy these in the right place and the right time. Build up workforce of 250 individuals by the beginning of June ,150 on the ground by early June. Deficit of 136 individuals. Trying to get 150 on the ground knowing that as we open the economy, we will need more people.

The link between the testing, the case investigation and the contact tracing has to be as local and close to the point of care as possible. Looking at PCPs, FHQC, and LHDs. Hire people who are closely linked

with the patient. Government tracing and tracking triggers people, so we need trusted community members. We need to go to FQHCs and other parts of the delivery system. We want your support to help build the right type of workforce.

Strategy. Forecasting 3 weeks ahead county by county across 10 regions of the state. Each county LHD will forecast staffing needs for contact tracers and case investigators. They will submit that to the collaborative and we will combine with public health data about case rates in each county and forecast using that data how many additional case investigators will be needed in specific counties.

Create a pool of case investigators to pull from and draw in others. We will pick people who have done this work before, they are from a primary care practice or other entity where they can hit the ground running. We will rapidly onboard, train and deploy folks. AHEC's role is to develop the training. It is 20 people cohorts with 2-3 trainings a day each.

Modeled this program after Partners in Health and what they are doing in Massachusetts. They have 30 years of doing this work globally. They have strong FQHCs and local boards of health they are working with

Ask to FQHCs. Requesting for direct referrals of non-licensed staff. Salary range is \$17 hour base and up for team leads and supervisors. If you have staff that meet that criteria and are at risk for furlough, we would love to contract with them.

Sent direct email inbox. cctc-staffing@communitycarenc.org

Send them to the application portal that is on our website. We are calling it a quick-start method. We will pull those folks in

Don't want to disrupt employment relationships.

Will be contract staff; no benefits

Looking for full-time staff. Trying to build and augment the infrastructure that is there. WE haven't considered part-time but open to figure out. It will run 7

These will be contracted pos

6 months long contract for CCNC

Length of individual work will depend on local need.

90% of work will be telephonic. When unable to contact someone, we will have people who are willing and able to go into the field. CCNC will provide the PPE.

Download a soft phone on individuals' own computer. State will be implementing a new contact tracing and symptom monitoring application statewide based on what Microsoft has done. Training on how to use that, document interactions and send text to individual to check on daily symptom surveys

Scott Shone

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Identify individuals who test positive for scars/COVID-2 and work with individuals Tom was talking about to identify their contacts and test them as well, as appropriate. Test process has been a challenge from the beginning.

Challenges on the supply change through the process of wrapping up testing. NC has been in a good position. Set up partnerships with hospital partners and labs to provide as much testing as possible as the supply change permitted. About 3 weeks ago, averaging 2500 individuals tested per day. As we began to identify ways to stay ahead of the curve, clearly a need to ramp up testing.

Sec and Governor formed Testing Surge Workgroup – representatives of the department, public, private sectors, NCCHCA, hospitals, clinical community, NCMS. Goals: Assuring we have ample capacity in the state; Assuring access to that testing through collection of specimens.

Substantial capacity for testing enough that we could easily double or triple through testing in the state. Where are the barriers to doing additional testing. Supply chain on the test side was more robust. Federal government began to allow additional test modalities for the virus. Strong clinical lab system in NC. Diversified our tests so not all drawing from the same manufacturer. Very good capacity now.

Need to open up collection sites, especially in areas that have been underrepresented for collections thus far. We want to target areas and drive testing at the local level to increase testing to get to the

Now averaging 5-6,000 test per day. What we identified through surveys at the local level, collection level. People are not seeking testing. Supplies, swabs, PPE is also an issue.

Focus on trying to encourage people to seek testing and for providers to open up testing to those individuals. A week and a half ago: new guidance memos for providers and

Have been more restrictive – only those with severe symptoms and hospitalizations. Now, trying to encourage providers to test any individual with symptoms of COVID. State lab continues to prioritize high risk, hospitalized, essential workers, congregate living situations, etc.

Trying to ramp up accessibility of testing across the state. Swabs and transfer media have been a problem. Have a call with federal government to discuss their assistance with provision of supplies. Swabs and transport media.

State lab providing collection supplies for those submitting back to us. We want to provide supplies in concert with the commercial labs. Most of commercial labs available. We want to make supplies available to you through a centralized process.

Assistance: Work with local LHDs to determine how we can encourage more collection? Collection events: reach out to local communities to be tested? That is where the health centers are the focus at the moment.

Commercial partners say they have ample supply. We can address issues with commercial labs.

FQHCs can readily request PPE through the state stockpile. There is a website where you can request: <https://www.ncdhhs.gov/divisions/public-health/covid19/health-care-providers-hospitals-and-laboratories/requesting-ppe>

Q: As part of the Governor's plan to expand testing. What are the thoughts about testing using standing orders and broad criteria as opposed to having a clinical evaluation prior to testing? Are there plans to change or broaden the testing criteria from DHHS.

A: Guidance issued on April 20th: Clinicians should test anyone they feel may show signs of COVID. Not encouraging widespread of asymptomatic, although they will be part of contact tracing and they have been part of congregate testing strategies. No push to do standing orders because (a) there is legal authority for local health to pursue testing. We rely on the clinician's judgement as to whether or not people meet the criteria for testing. Focused on relationship between patient and provider to determine who gets selected for testing.

Q: Is the state lab going to allow more testing? There are certain criteria for state lab specimens to be tested at the state lab.

Q: Are there any preliminary results that you could share regarding COVID prevalence from the ILINet surveillance? On the other hand, are there any plans to estimate prevalence of antibodies among the general population - I believe NY did a similar thing with a sample size of 3000.

A: Not broadening criteria at state lab. Not meant to be large scale testing center for states. Currently doing 400-450 specimen tests per day which is how many we can do. Hospital partners and commercial labs are using much lower % of their capacity. State lab traditionally doing more surveillance and identify flare ups. Working through ILI provider network to do more surveillance. A piece of capacity is to do surveillance.

Q: How supportive do you anticipate the federal government to be when it's been described as the "supplier of last resort?"

A: We've had recent success getting support for lab supplies. At the federal level, there has been change of who is responsible for certain activities. Reasonable to anticipate some level of support.

Walgreens being set up in Durham. Walmart being set up somewhere else as collection sites. We are trying to work with Local health departments for them to determine where is the best target. There will be coordination to drive high thru-put collection sites.

Q: Is the state planning or coordinating to deploy rapid pcr testing or antibody abilities?

A: The only rapid diagnostic test is the Abbott ID now instrument. We are not coordinating distribution of those. Abbott did not have substantial instruments and the ones they had were purchased by federal government. Government distributed the ones they had to where there seemed to be low testing and capacity. But test supplies continue to be a challenge. State lab is providing reagents to those sites. No effort to do rapid pcr testing. Antibody tests on the market now have performance issues. Vast majority have no FDA review. IN studies internationally and nationally, false positive of 15-50%. So, not encouraging those. There are a handful that have emergency use authorization from the FDA. In general, the rapid antibody tests have had flawed rollouts and usage has been a problem. Because not reviewed by FDA., they must be performed in high complexity testing center. Cannot be sued at any test site. Must look at requirements of those tests. Not deploying any antibody tests for regular testing. Used in research testing settings. Some UNC/Duke/Wake others. Not diagnostic.

Four main swab types. All approved because of shortage of nasopharyngeal swab. nasopharyngeal is best – most sensitive swab. It must be collected by a provider and requires the most PPE. The NP swab is the only type for asymptomatic individuals. On the other end is the nasal swabs. These are in huge supply – easy to make. But least optimal sample. Less virus right in front of the nose. It has huge pros because an individual observed by a provider can collect themselves. CDC says nasal swab should not be the first choice or even used for asymptomatic individuals. Only for those with upper symptomatic individuals.

Yes, if going to symptomatic triage and individuals identified as having symptoms, nasal swab is acceptable way to have higher volume with low PPE usage. The slide is not what NC DHHS has put out in terms of testing. LabCorp has home collection kit – it is only nasal swab and they only have permission to use with symptomatic people

Coordinating with LHD to make sure there isn't duplication of effort. We've run into duplication of effort in some areas. Try to maximize collection with minimal impact on your PPE or your workforce. Test Surge workgroup is trying to share models for how to facilitate. Guidance forthcoming to the local level. The who, the where and the how. Some is driven by local conditions. Set up drive by may be a good way to test people who are symptomatic.

Comment: I spoke with a VP at LabCorp this morning and he stated that CDC refreshed guidelines yesterday. He also stated that Lab Corp was going to limit NP to hospital systems and that nasal swabs kits will be sent to outpatient centers ie health centers. This is due to global supply chains.

HHS COVID-19 Uninsured Program Portal

There is a lengthy registration process. You must validate your TIN with Optum who is administering the program. Must share names and SS or drivers license info of the patients you have served. You can start filing claims on Wednesday, but you can sign up yet. We don't know how much money has been allocated. Funds could be depleted quickly. Encourage you to get set up in this process.

Considerations re: HHS COVID-19 Uninsured Program Portal

- Steps: registration process could take 9-15 days (validate your ITIN; set up Direct Deposit with Optum; submit roster providers for whom you're billing)
- What's covered: DOS on/after February 4: testing (specimen collection, diagnostic, and antibody testing; testing-related visits in office, telehealth, urgent care, ERs); treatment: office visits, other settings
- Starting Wednesday (5/6) can submit claims -- pays at Medicare rates. undocumented immigrants eligible (likely not eligible for the Medicaid option)
- Takeaway: GET SET UP. We're looking for guidance but so far haven't heard -- but the portal is being widely promoted; unclear how many billions allocated to this -- large hospitals and health systems could drain down funds fast given costs of treatment

Q: Patients have to submit Social security number?

A: That is asked but they don't have to. It seems they may have to provide a government issued ID number so they can validate the individual who received the service. We are uncomfortable with the level of detailed patient information being collected.

Still no info on how \$600 million to expand capacity/supply at FQHCs from last week's federal legislation will be used. HRSA is working on it. We think this is for expanding capacity and will be flexible -- not necessarily for covering lab costs.

NCGA Update on Testing Coverage

- Provisions in both house and Senate bills that would allow NC to adopt federal option to use Medicaid to cover the cost of testing for the uninsured. Just for testing (likely retro coverage but unclear what date), not for treatment. Expected to pass a package tomorrow. That may be one way to get testing paid for. We know some labs are holding their uninsured claims from FQHCs, so that may be a way they would get paid for lab costs.
- Provider relief fund covers lab costs, specimen collection, diagnosis, and office visit related to that testing. Broader category of claims covered under the reimbursement model.