NARHC Webinar
Thursday August 27, 2020
Moderator: Nathan Baugh
Speakers: Dr. Keith Davis, Mandy Shelast, William Massengill

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Covid-19 Testing – What RHCs Are Doing for Their Communities

Nathan Baugh:

0:06
Hello, everyone.

0:08
I want to welcome all our participants, my name is Nathan Baugh and Director of Government Affairs, the National Association of Rural Health Clinics. Today's webinar topic is ... Testing what RHCS are Doing for Their communities. This webinar series is sponsored by HRSA Federal Office of Rural Health Policy, has done in conjunction with the National Association of Rural Health Clinics. As you can see on your screen, we are supported by this co-operative agreement, and that allows us to bring you these webinars, free of charge. The purpose of the series is to provide staff with valuable technical assistance and RIT specific information. And, in fact, this is a webinar that's designed to preview coded 19, testing, specific information, including information about the funding that ... test.

1:05
Please help us spread the word about these free webinars by encouraging anyone who may benefit from this information to sign up, to receive announcements regarding age topics and speakers at the ... Hub website, or at the ... website. When we get to the Q&A portion of the presentation, which we will have, we will open the chat box to allow participants to ask questions, so you won't be able to see it now, but, you will, at the end. And, a recording of today's presentation will be posted on both the RHIB Hub website, as well as, the ... website, with links to the slides and transcript.

1:44
Our speakers today, which I'm happy to introduce, our doctor Keith Davis, from Shown Family Medical Center, and she's shown Idaho, which is an independent rural health clinics, clinics.

1:59
Doctor Davis will be followed by Mandy Shelast, who is the regional Clinic Director at ... Hospital, which is a part of that Aspire S health system, and the upper peninsula of Michigan and Wisconsin. She's also on our board, so thank you to Mandy.

2:17
And then, finally, last but not least, we have William Massengill, Mr. Massengill with the Benson Area Medical Center, and dance in North Carolina. And William is also in an independent Rural Health clinic.

2:36
So I'm going to turn it over, first, to doctor Davis, who will talk a little bit about what he has been doing to Do. Coven coven 19 testing.

2:47

So, doctor Davis, I'm going to make you a presenter right now.

Dr. Keith Davis:

2:50
OK, thank you, Nathan.

Nathan Baugh:

3:03
And, we can see your screen now.

3:05
So, just go into presentation mode, and you should be able to control it from there.

3:15
See.

3:20
Click on the front of the beginning right there. You can click on it once, but it didn't take, there we go. OK, there we go.

Dr. Keith Davis:

3:28
Welcome, so, as Nathan said, I'm in shown Idaho, South Central Idaho.

3:39
This is an independent RHC, the rural frontier part of Idaho.

3:44
We're the only medical clinic in a county larger than the land area of Rhode Island, approximately in that 3500 is incorrect that we did an updated count, it's 4200 active patients served by me as the physician, ... to NPs a C and M and L. CSW affirmed D And two, C D C S is wishes.

4:10
The new term for a C D, we serve all ages, including obstetrics, practice, assisted living facilities, skilled nursing facilities, and house calls.

4:23
We're in NCQA recognized patient centered medical home.

4:28
I started the practice in 19 85, we became an independent RHC in 2002.

4:34
The demographics of the Practice, 79% Caucasian, 20.9% Hispanic, a very small percent of African American and American Indian, or Native Americans.

4:48
We have 43% male, 57% female. By the way, these figures are updated from the handouts, It's currently available on the slide set, but an updated version will be posted after this session.

5:03
Are age demographics, you can see, are typical of a family medicine. Practice seeing all age groups, and we have about 40% of our patient visits as Medicaid visits.

5:15
So, what are the barriers to using your ... funds? As most of you have already found, there's a lack of availability of coronavirus, 19 testing instruments and kits.

5:27
Also, the spending of the funds needs to be related to treatment of covered 19 in some way.

5:35
We recognize that we had an Albert Alere ID now instrument, which could do coronavirus testing.

5:41
However, all of the test kits were being directed by FEMA to a district health offices, at least in Idaho. That's what was happening, and I'm assuming that a lot of that was going on around the country.

5:53
As of today, we had ordered 360 tests from Abbott and that order has not been filled, but more on that later.

6:03
We had an internal staff discussion, and three immediate priorities were identified for our particular location.

6:10
We needed more exam rooms. We only had five.

6:14
We wanted to get rid of carpet and get rid of cloth furnishings for materials and surfaces that were sanitize the Boll.

6:22
We wanted exam rooms that could be isolated from other clinic exam rooms. And we had a waiting room that had a separate entrance that would allow us to do that.

6:32
So we remodeled our sales waiting room. We had an north and south waiting room, the main entrance into the north.

6:38
We used an unused office and two exam rooms were created as well as a telehealth room to exam rooms, as I said, accessible from separate outdoor entrance for cauvery 19, patient isolation, or other patient isolation purposes if needed.

6:56
We had all the carpet removed and replaced with a waterproof laminate That is easy to sanitize. We replaced all cloth furnishings with chairs that had medical grade vinyl, that is easy to sanitize.

7:08
So here's some before and after photos for you.

7:11
This is the south waiting room as it's being remodeled into exam rooms and you see one of the finished exam rooms on the right.

7:21
Our conference room with carpet before and the new flooring after.

7:28
In furnishings, we had the cloth fabric type chairs replaced with the medical grade fabric that you see there on the right.

7:38
Yes.

7:40
So although we have the abbot later ID, no instrument, we're still unable to obtain tests.

7:47
The ID now tests takes about 15 minutes up to 15 minutes positive as faster than that.

7:54
We've collected specimens by nasal swabs to send out to our reference lab for Corona virus testing. Our turnaround time through the reference lab has varied from one day to five days, and as of now, we've tested 91 patients with turned positive to date, one of those patients hospitalized, no deaths.

8:14
Our reference lab has stopped doing testing for asymptomatic persons such as those, wanting a test for fishing in Alaska.

8:24
Today's headlines in the newspapers, that Abbott has had approval of a buy next now. Rapid Coronavirus 19 test card size kit.

8:32
That's $5 according to the newspaper and so that could be promising or it could be something that's approved and not readily available.

Nathan Baugh:

8:44
And I'll, we're not actually doing questions and answers right now, but that's the end of my presentation. Thank you.

8:53
Thank you, doctor Davis. And we will, I do want to circle back on the rapid test kits, I'm glad you brought it up, but we'll, we'll circle back on that in the Q&A portion.

9:05
So now I'm going to make Mandi the presenter.

9:08
Mandy, you should be seeing it momentarily, and Mandi will provide us the provider based perspective.

9:19
Because she works for our system. Mandy, we can see your desktop and thank you, doctor Davis.

Mandy Shelast:

Can you see my screen?

9:31
Great.

Nathan Baugh:

9:33
Yeah, we see your desktop. We see the Desktop, OK, one moment.

9:40
Oh, we're going to do this.

9:44
Our good Yep.

Mandy Shelast:

9:47
OK, so, um, Thank you. Everybody is so good to be with all of these rural health appears across the nation. I see there's 501 of us on today, so there's quite a few of us there. I want to talk to you a bit about ... 19 RHCS and the communities that we serve.

10:07
So, what I'm going to be talking about today is who I am, what we which communities we serve, what we've done with our Club at 19 funds, and kind of how we decided what to do with them, and then challenges that we've had to date. And, you know, one thing, as I was preparing for this presentation that I was thinking about, was, No, I'm just going to try to get this to play a little bit differently. But I was thinking about, you know, I really like to go shopping. And if somebody gave me money, I mean, I should be able to spend it, right? And I'm sure, myself, included in all of you on the call, have had some trouble kind of deciding what to do with these funds, and then actually trying to spend them. So that's one thing I wanted to talk about.

10:47
This is me, I'm the last Hi! I'm Mandy and I'm from Michigan, as Nathan mentioned. I serve as the Rural Health Clinic, that regional clinic director for some rural health clinics that are owned by some parents cause in Michigan and my system spans from the northern eastern end of the Michigan Upper Peninsula down into Wisconsin.

11:07

So the region that I'm gonna be talking about today is the Western African in Michigan and the circle there, and I'm sitting talking to you from the very north, most tip there, almost in Canada, Which is OK, because my husband is Canadian, about my community. I wanted to share this with you, so as you're listening, you can kind of compare and contrast, you know, is what She's talking about, larger than where I am, or Is it about the same. So that circle that I showed you on the upper part of Michigan there has about 173,000 residents that we take care of. Our population up here is primarily geriatric. We have a strong Finnish background, Lots of people who came from Finland years ago and they still live here. Our poverty rate is 17.3%, which we know is 5% higher than the national average or average household income is $43,000, which again is $21,000 less than the average the average household income of an American today.

12:06
So if you look at the topography or geography of our region at unique thing about us is we get 283 inches of snow. So, not only do we have a lot of trees and a lot of miles in-between our patients in the rural health clinics that take care of them, but, you know, five months out of the year. These roads are sometimes not even passable. So, it creates some challenges, which I'm sure you guys all have your unique challenges in your clinics as well. The clinics and to be talking about today are attending provider based, provider based perspective, their own for Critical Access Hospital. And we deliver about 150,000 visit through those 10 clinics to the patients and our communities.

12:49
I just wanted to put, now, these numbers, if somebody goes to Google, are probably a little bit outdated because they are from a couple days ago. However, Michigan has had a high prevalence of covert 19 positive patients and we have seen a lot of those in our clinics here. So we are we were dealing with it.

13:09
So, we got the ... funds, like you all did at the, in April. And we were really excited. I think, that we were pretty surprised and shocked by the amount of funds that we got, and amongst that were provider based. So our Critical Access Hospitals had received 75 other grants and, and items that were related to cope at 19, and as these things started hitting us, we were wondering, how are we going to track this? How are we even get to keep track of which funds are what, and how we're gonna spend then? We have a great fiscal team here in our region, and they helped us to just get our minds around. And that's the first thing we wanted to do. So we created a spreadsheet, just an Excel, very easy, but all of the grants on the bottom. And then as we started to get invoices and things like that that were related to money that we're spending on the grant, we were able to then just paste them into the Excel. So when an auditing opportunity comes in the future, we can easily go in and take a look at that.

14:08
So, on the left or on the right, I want to share with you a couple of things as these funds came in, and we we already covered in our communities, and we have to find ways to test these patients. So, prior to the funds coming in, we had set up a lot of alternative text site. This graph that you see, what the cones, that's actually an ambulance crash, which I think is our best opportunity for testing in the UP because our patients can actually drive in. one side, Get flagged in their car and triage and they can drive out the other, which is pretty cool. Several of our other

clinics and create a just drive up testing with vulnerable signs. I think we actually painted on one of our handicap reserve signs there to denote a covert testing area, and then we put up walls and things like that. So that we could alter the inside of our clinics to make sure that they were appropriate and safe for our patients to come in and receive care.

15:04
So, now that we have these funds and we knew we needed to track them and we had a good way of doing that, what did we do with them?

15:10
How did we decide what to do with these funds? So, we started out with some internal meeting. On the left UCS Appropriately social distance but those are the providers from our RHCS talking about how are we going to spend the, what, what does our community need most from X And we really leaned back a lot on the Emergency Preparedness Regulations that all came into RFC is a couple of years back. And we're very thankful that we had done tabletop exercises and understand what an EEOC was, a new, how to integrate in, with our hospital in our region, so that we could figure out what to do with the funds. So, we really started by doing internal meeting. What is it that we believe our patients and communities need from us?

15:51
And how are we going to, how are we going to deliver that LinkedIn with our communities? So we were talking with ambulance companies, different universities. Different, you know, the grocery stores in town, because they had critical infrastructure in place as well. What are they doing? As we were able to link in there, we were able to jump on some calls with our local health departments. We have to, because our geography is pretty big. But, they were able to host calls with all of the stakeholders at the table. So that none of us were duplicating work. We knew that we needed to get out and help people, and we didn't all need to do it. We just needed to do it together. The state of Michigan had some pretty great statewide meetings as well, so they offered meeting from our governor, that we could talk about what was going on at the hospital in the clinic. Different groups within the hospitals, like a lab group, got together and talked about testing opportunities and things like that.

16:41
So, the bottom, we were actually wanted to get out and do these conversations, and talk with the community and get their feedback as well. But with social distancing, that was really tough. So we couldn't do that. So in the orange there, in the chair, there's just kinda weird setup. But that's actually our medical director and he's talking with a local news Pachter VX. I think just video chat, kind of asking the community, what is it that we can do? So we found safe ways to engage the community.

17:09
From all of that talk and everything that we know wrapped in from the community, is in the school and everything like that, we, we knew what we needed to do. We needed to catch people. we needed to get that available so that our critical infrastructure workers, when they were feeling ill could get back to work and get tested and figure out a bad Kobe. You see on the right here, there is a lady with her arms up very excited. She is our regional president and she was very excited that we knew what we're gonna do and how we're going to give back to the

community. So, we decided we're going to take the covert funds and we're gonna send them on. Some analyzers are gonna get some .... We're gonna get them into our RHCS, are going to be able to test people and we're going to help our community and we're very excited about that.

17:52
Well, we realized that that was pretty challenging. So right now we have three of the ... analyzers and two of the ... boxes in our clinics. and we have no reagents.

18:06
So we're able to purchase the reagents yet the government had actually sequester those to help out with our nursing home patients among the nation, who are unable to get those reagents right now to do what we know what we need to do test these people.

18:22
We had some testing capacity concerns as well, so it through all of the community engagement that we did, we were able to find testing for our patients. Prior to us getting those analyzers, we were able to work with our state lab. They had some capacity, However, that's nine hours from where most of the clinics I'm talking about are. So it wasn't a great option for people who needed to be tested rapidly rapidly with a rapid turnaround. We are very, very fortunate to have a local university around who got an analyzer. So they were able to actually process 150 tests per day from those can see that I'm talking about, and help us to get turnaround time within three days when some patients were waiting 7 and 8 days for tat.

19:05
We were able to work with the state as well for the National Guard to come on up and help us out in communities where there just wasn't people couldn't travel, they couldn't get anywhere where it was. There was testing. So even without the analyzers and what the government taking our reagents and things like that, we were still able to deliver testing, which we so badly wanted to do to our to our patients and communities.

19:28
So, um, testing capacity right now is a challenge for us, as I'm sure it is. For most of you, I talked about partnering with the local university. Well, their students are back now and they need their analyzer to really focus on their student population. So that option has that, has decreased for us.

19:45
The testing turnaround time from our state lab is increasing, because more things are going there. But I talked about linking in with your community in your safe. And what we've been able to do is get on with the local group of lab leaders from across our state. And they're helping us to say, hey, the state lab is really bogged down, but next gen can take the test. And they can get back to you within three days. And that's so important because we're seeing a lot of people with Kobe type symptoms that are MS first responders that maybe work in healthcare that maybe work in mail delivery and they need to get back out and do their jobs. And they're waiting on these tests to come back. So we're still able to deliver, though.

20:24
Then one of our challenges is definitely spending the funds. We know what we want to purchase and we know what we want to do and give back. But we were unable to purchase the reagents and some of the analyzers that we know that we need to add to do. So, on the left there, I just

want to show, that, is this no outside our window? Just a couple of months ago, so I wasn't lying when I said we get almost 300 inches of snow. And they call us you for some of our patients and put that on our window for it. But there's definitely challenges out there. And that's why we're all on this call today. So we can talk as peers about how you've been able to solve your challenges, and we can bounce things off each other. So, I just want to say thank you very much for the opportunity to talk with you today, and I look forward to seeing some of the questions in the comments section.

Nathan Baugh:

21:15
Perfect.

21:18
Great. Thank you so much, money. That was perfect. Now, I'm going to turn it over to mister William mashing go from Vinson, North Carolina. And I think we're gonna start with a video about about maybe eight minutes or so.

21:33
And then mister Massad going to have some slides and then we'll get into the Q&A portion. So just bear with us a little bit as the video buffers, but mister ... TV.

21:46
You should see the presenter coming your way.

21:58
So, we see your screen, and the video will pop up shortly, I believe.

32:25
All right, mister Massad, I think we're done with the the video now.

32:32
So I believe you can share your screen just to switch to the PowerPoints.

32:55
If you want, I can bring it back to me and then pass it over back to you again.

33:02
We're not hearing them.

33:06
We're not hearing you.

33:12
All right, so we're coming back to me. We, we just, I think I see that you're unmuted now. I'm going to make you presenter again and so now this time to share your screen.

William Massengill:

33:34
OK, Thank you all, were glad to be here, this is ..., that is with me today. She's our Financial Operations Manager, and video gave you a sense of what we're doing here with the help.

33:49
You may have seen the name, the Medical Center, the help we changed, that can do, to reflect our recommitment to this community and provide quality care up.

34:12
So, if you're looking here, you see that we're right.

34:16
Whoa.

34:25
It looks like we're having some bandwidth issues.

34:30
OK, now it now, now I can see it.

34:34
So we're located here in the North Carolina 30 Miles south of Raleigh and about 30 miles north of Fayetteville, area, and purple that you see is really the area that we service. It's retail. And, uh.

34:50
Really, at the urban rural divide, it, you know, Raleigh as urban area, but if you look around at this, an area is very rural and ... does love agricultural areas. So, we're really a mix there.

35:07
Yes?

35:11
Yes.

35:25
*** Alan Turner.

35:40
So, just to share with you, the slides are having a little bit of a problem for me, dancing to the next one.

35:50
Oh!

35:57
So, well, yes, yes.

Nathan Baugh:

36:01
So I think, so I'm, I'm sensing a bandwidth problem and I see you've got a lot of tabs open.

36:08
Do you want, do you want to maybe get it like preloaded, and then I'll come back to you and I can do my part.

36:19

Ah, Yes OK All right. Let's do that. And you might want to consider turning out the webcam just to maybe help with that bandwidth a little bit.

36:29
Thanks.

36:31
All right, so, we'll do this a little bit that order, Um, should pull up my screen now, and I'm just going to go over a couple of things, then we'll go back to William. Let him finish off, and then we'll go to Q&A here.

36:49
First thing I wanted to mention is that we are, as I mentioned in the intro, we're working with the Federal Office of Rural Health Policy, but we also, as part of that partnered with ..., which is the National Organization for State Offices of Rural Health. And.

37:09
They are, obviously, they work with your State Offices of Rural Health to provide technical assistance.

37:16
But they asked them to share this with you all.

37:20
And they did set up a, an e-mail as you can see at the bottom of your screen, RIT Covert Testing Info at ... dot org. So, that is where you can go to get more information from No score and on how they're going to be helping us with the, with this TA project.

37:42
Moving on, I wanted to briefly talk about some of the data collection requirements for the ... testing money.

37:53
Now, we all know each RHC got just under $50,000 per Clinic.

38:02
4 coven 19 Or Testing related Activities.

38:06
In the terms and conditions of that money, are these two bullet points, all right.

38:15
You can read them yourself, but it says essentially that you have to comply with data collection requirements as determined by the Secretary.

38:27
And then you're going to have to certify that any information that you provide is, is as accurate as you can make it. OK, So, if this, there is going to be a data collection requirements that you agreed to follow, you, Know, when you accepted the money? And accepted the Terms of Conditions? So, I just wanted to.

38:53

I'm getting a text, that, they are not seeing my screen. Or, you see my screen?

39:02
Yep, OK.

39:07
Hopefully, folks are seeing my screen.

39:11
OK, I'm getting a few people saying that they can see it, so.

39:17
We will just keep moving on, and hopefully, you guys, it's not happening for most people.

39:25
The data collection process is still being developed. We're working on it both at a technical level. It will be probably almost certainly just a website that you go to. It should be relatively straightforward and simple.

39:43
The data is going to be organized at the Tax ID number level.

39:48
So, again, if you're in a provider based organization, you will report for the data across the entire tax ID.

39:59
If you're an independent RHC, which is one like Ben Scenario and Medical Center, then, you're just going to be reporting on that one RHC. But, again, the data's going to be already organized at the Tax ID level.

40:14
The questions that are almost certainly going to be on there, I can't say for sure, because notice is formally approved.

40:23
But, just want to flag for folks, so you know what is coming down the road, and it's it's very simply what, how many tests did your tax ID organization perform, and how many of those tests were positive. We will probably also ask you to provide any addresses where testing was being provided by your organization.

40:51
These, these testing figures are going to need to be broken out by months, and although we would obviously like the most accurate figure as possible and if you have your numbers at hand perfect. But especially early on, let's say. And maybe April or May, you don't know the exact number you are, We will allow you to estimate the number of tests.

41:21
Richard did.

41:23

I do want to just point out, so people don't, panic is that, rural health clinics are not required to do Kobe testing, but you are required to fund script tags for testing related activities. So the answer can be zero, in terms of the number of tests that you've done, but you're gonna want to, you know, have documentation that, perhaps, you are referring symptomatic patients to another entity that is doing testing. You're doing screening. You're doing some testing related activities with that money.

42:03
So I just, I just wanted to flag that even though this is the survey is going to be asking the number of tests, it isn't technically a requirement that you have to do testing, but you do have to spend the funds on tests for testing related activities.

42:23
I don't want people to panic about the data collection requirements. When the system is fully approved and ready to go, we'll have a full webinar just on the data collection requirements and how to accurately fill that out.

42:43
And it's, again, like I said, I'm confident that it's going to be relatively straightforward and not to administrative burdensome.

42:50
But just try to keep your tax ID, organization wide. Testing figures. And if you can have those by month, that's what you're going to want to track.

43:06
So, with that, Mr. Massengill, are you ready to take the screen back to finish out your presentation?

43:20
Alright, so I'm gonna, I'm gonna pass it over to you, hopefully, everything, as loaded. And I'll make you presenter now and then we'll transition back to Q and A as soon as Mr. Massengill is done.

43:41
Perfect! We can see it's in the PowerPoint, and.

43:46
Yeah, I think, I think we're good..

William Massengill:

43:50
So, you can see here, in the purple that is up, right In the rural, urban divide, their close to Raleigh, 30 miles from Raleigh, But just right around us, it's a very rural area, and also, as a county in a region that's shifting and changing, but still a lot of rural and agricultural areas.

Nathan Baugh:

44:21
So, why do I, Why don't you do from current slide, Hit hit from current slide there.

44:30
Just a little down.

44:33
Right there.

44:40
Good.

William Massengill:

44:42
OK, so, uh, over 90% of our patients, ear Reside, either in Johnston County's was the three we service and 14.4% of the county level or says .... The residents. In those two counties live below the poverty area.

45:05
But 26.9% in Sampson County.

45:18
So where businesses located, though, we have a poverty rate is about 31%.

45:25
and it's greatly exceeding even the 2 tier 2 counties that we are, we serve. So it's a much higher cause, poverty, right here events.

45:36
A study by local law, government.

45:41
Oh, final Jake hospitals. Did a father a tier three counties, like we're in here.

45:50
There's a lot of pockets of poverty, and they've listed the municipalities of the areas here, and this is one of those, and we serve that the whole art, starting here in Johnston County.

46:08
While the poverty rate, or the child poverty rate for children in Johnson County is 21%, the number of children living in 72.

46:20
So we have a lot of, we have a lot of children live in poverty, poverty.

46:28
How does is, where you're going but how you spend the money with? Your doctor Maynard addressed a lot of that. Doctor Maynard serves as the Chairperson of the Charleston County Health.

46:42
And he was actually with Health Director and all that Activity's planning LT on how, what needed to do as far as to address the testing in our county. So for us, as you can see, the main priority was how are we going to address it?

47:06
As soon as this is, we found that there was the date here.

47:15
Do we encounter any unexpected problems? We've sort of addressed that. We did have a problem of TPE, one time. We went out everywhere. They cool, the Internet trying to get EPE and we've actually been able to have that in place of the entire time. Also, there was some testing issues.

47:38
With supplies from the West side Gnostics was very good at helping us identify testing and we've certainly been able to address those concerns.

47:52
Have we spend all our money, the $49,000 that we got? And we've been, we've been fairly conservative calls, least felt that this is going to be an issue that's Google for some time with no vaccine inside this point. So, we try to utilize resources like the foundation money that we got this other resources.

48:15
So that we can let this way that we got from HHS taught us throughout the whole time. Doing the code. The testing, as everyone knows, and provide the resources for people is expensive.

48:27
And certainly, if we hadn't had all this funding in place, we would not be able to maintain a positive bottom line to be able to pay salaries at all. So, we have is fairly conservative, but we are trying to spend that lake judiciously throughout this process.

48:50
That's all.

Nathan Baugh:

48:57
Alright, perfect. Thank you very much, Mr. Massengill.

49:00
I'm going to pull it back to me and then we will get into the Q and A portion.

49:07
So Cate, if you could pull up the chat box.

49:13
Um and doctor Davis, Mandy, you guys get ready to unmute yourselves as as some of these questions come in. I will, I will start it by circling back to what doctor Davis references at the end of his presentation.

49:34
Where you mentioned the new approval of the, A Rapid Test by Abbot Labs by the FDA. And it sort of circles back to something that I've been trying to ponder for awhile, is I'm sure we all see the tasks get approved in the media and the news.

49:55
And, you know, When does How does it get translated from being approved in the FDA? And indeed, to be widely circulated, where are you guys?

50:10
Where are you? Where are you looking and checking to see how you can get access to these newer technologies?

50:24
Do you, for example, if you go, doctor Davis, would you go to the, you know, somebody in the state of Idaho, would it be the State Department of Health that you would trust to be the authority on, OK, hey, we got this new test testing technology, and we're promoting this now.

Dr. Keith Davis:

50:47
Thanks, Nathan. I tend to go to my Laboratory Accreditation organization and get some guidance from them.

50:54
There, only a few major accreditation organizations in the country.

51:00
There's Colla, there's Cap, there's the Joint Commission.

51:07
And if you have a laboratory that's doing more than wave testing, you, you're getting an accredited through one of those organizations, And they often have some laboratory expertise that can be useful to you.

51:19
A few, do your accreditation through CMS, then that's probably not an option. But if you use one of the private agencies, that, that could be very helpful.

51:32
The major medical suppliers, Cardinal, Henry Schein, and so forth.

51:37
They also, a lot of times, the ordering people are fairly aware of which machines are available versus back ordered, and sometimes you can get a machine and not get the reagents, as was mentioned earlier.

51:52
So, sometimes your suppliers can be helpful as well. Not so much on the quality of the tests, but on availability.

Nathan Baugh:

52:05
Anyone else want to weigh in on that.

Mandy Shelast:

Yeah, Absolutely. I think what doctor Davis responded is absolutely accurate. You know, just know, you're not in this alone. If you're an independent rural health clinic or provider based, it doesn't matter, There's so many of us out there that are going through this, get involved with your state, in the state of Michigan. All of the ladder lab, director there. Anybody who has something to do with lab jump on a call once a week and they're sharing what they know. They're sharing conversations with, their accrediting bodies. They are sharing conversations with their vendors. So, just get out and talk and ask questions. And there's people that will help you.

Bill Finerfrock:

52:42
William, do you have anything to add?

Nathan Baugh:

52:45
Yeah.

52:48
All right.

52:49
So we have our questions coming in now in the question box. So we're going to try to get through these as fast as we can.

52:57
First question is from Harriet Steinberg, who asks, Is there a cutoff date by which the $49,000 has been sent? And I'll just answer that, one at the answer is no. Not enumerated by the government.

53:12
Yet, Presumably, there, there will be one in the future, but I don't think it's something you have to worry about yet.

53:24
You know, as soon as we learn that there is a cutoff date, we will communicate that. But that is not something that I would worry about too much Now.

53:36
Next, next question. I know some people had issues seeing my slide. Bottom line is that.

53:46
Collected a number of tests that you're doing, and the number of positives that your organization has. And you'll be golden during the data collection when we, when we have to do that and know that data is coming, but it shouldn't be too difficult.

54:02
Next question is from Mark Lynn, Hi Mark. Who asks, How do you bill Medicare for the collection of Covid-19 samples?

54:12
I should ask you that question.

54:14
I think you know, the answer is that RHCS cannot bill simply for Specimen collection Medicare because it does not rise to the level of an ICE encounter.

54:24
However, if you did some other service, at that same time, that bid, right, The level of an IT encounter, again, face-to-face with the RHC practitioner that is covered by Medicare rise to that level of expertise.

54:44
Then, that whole visit would be billable because of that.

54:51
So, that it's, you know, that's sort of the system that we have imperfect as it may be.

54:57
All right.

54:59
Moving on. Next question from Mary Sweatt, who says, what is the meaning of doing a test?

55:06
Is that collecting the swab tending to test to a reference lab? Or does it have to be actually running the test? This is a great question, Mary, Particularly.

55:16
For the data collection portion, it will just be doing any of the components, but most likely collecting the swab that would count as performing the tests for the purposes of reporting and whenever we get that up and running later this year.

55:39
I'm taking a lot of these because they're technical. But I'm going to keep on moving.

55:45
Let's see.

55:46
Robert says, Are we able to bill for covid-19 specimen collection? OK, this is a similar question. We've been billing for the test essentially a cause for the Lab we outsource to, but we aren't billing for collection.

56:00
Let me turn it over to one of our panelists.

56:06
Do you agree with my assessment on on what to do for billing on the covid 19 testing?

56:12
How are you guys handling that? Maybe we'll start with you, Mandy.

Mandy Shelast:

56:19

Nathan. I agree with your assessment. And I really don't have anything further to add. You know, there's so many different ways to collect or define test collections. So it's definitely going to be different. Whether you're swapping and sending like next gen you're swapping, and sending to your clinic or hospital or a university, I mean, there's different practices that everything you said it is my understanding as well.

Nathan Baugh:

56:42
Right. And the payers are going to be different.

56:48
You know, Medicare, it is we have our unique billing structure for Medicare, but the private payers are probably they would have down, I presume you would be able to bill the private payers for the specimen collection portion.

Nathan Baugh:

57:06
Doctor Davis, what do you have some?

57:09
You have a good amount of private payers at your clinic, you bill the specimen collection portion.

57:19
For your private payers.

Dr. Keith Davis:

57:23
We, yes, we, we do, we also have though a, uh, an in-house phlebotomist who's employed by our reference laboratory. So if that individual clicks the specimen that we, we do not bill a collection fee. So it all depends on who collects the specimen in our situation.

57:44
So as Mandy said, it's, there's gonna be a lot of variables on how the collection is built and how the testing itself is built.

Nathan Baugh:

57:54
Mr. Massengill do you want to weigh in on billing.

Nathan Baugh:

57:58
We say this what they've said for Medicare course, the face-to-face is it has to be there and for the commercial, other payers, each one. You have to check with each one.

58:14
Nathan Baugh:

Nathan Baugh:

Right. Perfect. Thank you, guys. All right. Next question is from Anita Marlin, who is a direct addresses specifically to doctor Davis. She asks, how long have you ordered your supplies for testing from Abbott? She noted that she just ordered ours and where we were promised within five weeks.

58:38
You think She'll get it?

58:40
What has your experience been?

58:49
Doctor Davis, if you're speaking, you're on mute.

Dr. Keith Davis:

58:54
Very mix, my screen shifted for no apparent reason.

58:59
So the longer answer to the question is that I've had the Abbot instrument for several years and have been doing strep test and influenza tests on that, and ordered those kits for the instrument.

59:12
I put in an order for the Coronavirus test with Abit as soon as they announced that it was available.

59:19
And it was months ago, and I have not seen any test kits.

59:24
I'm told by the Albert Rep for this area that their manufacturing ability recently went from one million tests per week to five. No. I think he said eight million tests per week.

59:38
So, they're anticipating, they're going to be able to catch up with demand.

59:43
But I think five weeks from now, I would be cautiously optimistic that she might see that. But I've been waiting way more than five weeks, But there their manufacturing, I'm told has increased. So if that's true, then we hopefully will all be seeing product fairly soon.

Nathan Baugh:

1:00:04
Perfect. Thank you, doctor Davis. Next question is from Sharon Kerry. And I know it's a 301 will usually go a little longer.

1:00:12

As long as the questions that are coming in, we'll try to go, maybe another 15 minutes and answer as many of these as we can. Next.

1:00:20
Question is from Sharon Kerry, who mentioned that the reviews of the quality and reliability of the Abbott Covert Now tests has been pretty poor. Has that improved? So does any of our panelists have comments on the Review and Quality of the Abbot coven Now Test.

1:00:43
Smart use.

1:00:47
I don't know that it's changed from our From its initial presentation.

1:00:52
I, my understanding was that the positives were, were highly accurate.

1:00:58
The problem was sometimes the negatives were, were not and you get into accuracy, you get into specificity and technical technical terms that are probably the information in those areas, I don't have on hand for you.

Nathan Baugh:

1:01:19
Thank you, doctor Davis.

1:01:21
We will move on to Judy Lemmons question: Who could we use some of the money to replace out our front entrance door with an automatic door? I'll just answer this one, which is the answer is yes, because that it would be considered retrofitting your facility to better take care of computations because they're not going to have that opportunity for transmission.

1:01:48
I've answered that one before for others. So, I know that that is the permissible use of the funds. Next. Question is, from Jennifer Henrik. Hi, Jennifer.

1:01:59
She says that, we have increased our virtual visit and then we go to the vehicle to do covert tests.

1:02:05
We have had, to add, iPad, may have had to increase our internet to handle the increased load would disqualify as Kobi related for use of the bond funds.

1:02:19
Um, I guess, I'll go ahead and tackle this one.

1:02:25
I think that this is a little bit of a borderline, but as long as you are linking into covid testing related activities.

1:02:36

And most of this sounds like it could be linked. You should be OK.

1:02:44
I will say that if you're doing, if you buy a bunch of telehealth equipment, such as iPads and Internet, and you're doing a lot of telehealth visit while you're doing that because of code, it's math as directly related to testing as it needs to be for this fund.

1:03:07
So I would, I would suggest that if you could find something that's got a little bit more of a straight line from the purchase of the equipment or Service Directly to testing that, that you spend the money on that.

1:03:24
Instead, know, setting up a big Telehealth program and system is covert related but not covid testing related. So, I would just I would push you more towards the testing side of things.

1:03:41
Anita, I think I've already answered your question.

1:03:46
Next question we have is from Lori Whitfield, Trotman do these funds fall under the same federal guidelines as other funding, such as definition of equipment versus supplies, The extra recordkeeping needed as some of the funds are spent on a, then their service.

1:04:05
Um, Lori, I'm not fully understanding your question. Do any of our panelists want to comment on that?

1:04:19
How Mandy, how did, how have you been classifying the for just under 50 grand for testing?

Mandy Shelast:

1:04:32
Yeah, so we we have really classified it for those analyzers which we didn't have before like doctor Davis did, and we weren't able to just retrofit them to do the cover 19 tests.

1:04:42
So we put the money into the analyzers and the reagents for the analyzers and then the test kits for those.

Nathan Baugh:

1:04:52
Yeah, so I'm Lori, I think we're gonna have to have while we're gonna be able to help you, because I'm not fully understanding the context of your question.

1:05:04
Next question is from Bryan Kesler, As we have two providers, 1 DO, and one NP, we have an outside agency do our covid testing.

1:05:14

We feel a lot to what are responsibilities are and how to spend our money.

1:05:25
Anyone, I have thought that I'll open it up.

1:05:29
It sounds like they're looking for direction at a more, at an early phase. Does any of our panelists want to offer some, like, first steps about thinking, what they could do with their money?

William Massengill:

1:05:45
Well, I guess the question would be, but what are they?

1:05:51
Why are they outsourcing that rather than doing some of that collection within there?

1:05:56
They're own space with these questions.

1:06:01
They, the ones calling up and following up with the referring patients over, are the ones calling back and give you the result, or is that third party doing that.

Nathan Baugh:

1:06:14
Right, Mandy's, you do wanna chime in?

Mandy Shelast:

1:06:18
Brian, that's a great question. I think we're all at different stages, But, you know, I would ask some questions around, you know, is it the staff from the outside agencies is actually swabbing the patient? If it is your staff, you know, is whether you're going to be playing into the mix in the future? When your region, you know, are there things that you need to do to shelter, those patients? You know, is your staff going to start doing that? So just start thinking about how you're going to integrate with that outside agency, because I think all of us work with outside agencies just to get the test out at some level. But there's definitely ways that you can integrate and things that you can do within your practice to help, you know, spend that money for lack of better word.

Nathan Baugh:

1:07:04
Perfect, thank you, Mandy. Next question is from said Nielson. And we'll just do a few more here and then we'll close this out.

1:07:12
I know some people are waiting on the CEU code, which is coming at the end.

1:07:17

Should asks, would cost associated with remodeling your space for safe delivery of testing in the winter appropriate, be inappropriate use of funds? I'll just go ahead and tackle this one.

1:07:35
That I would say that yes, but I wouldn't necessarily use the term remodeling.

1:07:40
Because in the terms and conditions, retro fitting as explicitly mentioned as, something you can use the funds for remodeling as Mark So, you know, as long as you can link it to logical, logically to appropriate, retro fitting, or, or, or work like that.

1:08:09
That's related to testing your, OK. But again, I would call it retrofitting, not remodeling, and this isn't just an opportunity to use.

1:08:18
Just under 250 grand to, you know, just get fancier X, Y, or Z, know, ask aspect of your clinic. It's got to be logically related to, you know, how improving your ability to do covert testing.

1:08:36
So, doctor Davis showed you swapped out the floors from carpet to Heartwood.

1:08:43
That's obviously something that I can no. With a straight face.

1:08:49
Say that's easier to clean it, you know, more hygienic and it's better for Cauvery 19 testing so that's really the you just have to it just has to pass the haha test essentially and you'll be OK but again call it retrofit.

1:09:08
Alright.

1:09:08
Moving on, next question is from Ellen Schonberg who asks, do you feel that renovations in order to care screening patients for Kobe would be allowed expenses related to the requirements or changing out equipment such as temporal thermometers instead of typical ear thermometers, or cost chairs to healthcare approved.

1:09:34
So, I think I just answered this.

1:09:36
Most of those sound appropriate.

1:09:40
As long as, you know, they're related to covert testing, you can use the funds for that.

1:09:45
And if, if you're upgrading your equipment from something that could potentially transfer Covid from one patient to the next or from a patient to staff, to something that is can be cleaned and it's

going to improve the sanitation, sanitary environment, then it is an appropriate use of the the funds.

1:10:11
Um, next question is from Jill Ruined.

1:10:17
Who says that we have an RHC but do all of our testing at our Critical Access Hospital main hospital site?

1:10:26
The same patients that are our RHC patients are also the patients of the car.

1:10:32
Does this count as an allowable expense for RHCS, HHS dollars we received? Yes. Yes, it does.

1:10:40
Now, this is a pretty common situation where the hospital owns a rural health clinic or multiple rural health clinics. And in those situations, the hospital almost certainly is the entity that got the funding.

1:10:59
Because it was allocated to the tax ID of the parent entity.

1:11:09
And so on The hospital is allowed to use that fund at the add a different site other than the RHC, such as the critical Access Hospital.

1:11:22
But there is a there is a requirement that.

1:11:30
No someone from the RHC at least be involved in the decision-making process. Now, it is the technical language is the actually. and this is in the FAQ. So, I am trying to rephrase the FAQ from memory.

1:11:50
But it's someone from the are the organization, the ... organization that owns the RHC, has to be in the decision-making process.

1:12:04
So, essentially, it means anyone in your organization can make that decision. So, bottom line is, yes, you can use it at the hospital. There is a FAQ that's directly on this, that sort of equivocate how I have been doing in the last couple of minutes. So, I would advise that you take a look at the FAQs and look for that specific question where they talk about using the funds at the hospital.

1:12:34
All right, we're going to do one more question, and then we will get to the CEU and close this out. Last question is from John Angel.

1:12:44

Who says, Can we use the funds to hire someone to use specimen collection?

1:12:49
How do you track the employee expense if all of their time is not dedicated to specimen collection?

1:12:58
Um, mandi or William, have you guys used the money to hire, bring on additional staff specifically for specimen collection?

William Massengill:

1:13:14
We have not done that. We have not done that, but we have people better.

1:13:20
Whoops, we will use some of that money for the staff, and we keep a spreadsheet there.

1:13:32
Collection,

Nathan Baugh:

Right, to do you just kind of have them punch in and out, at the time timesheet link.

William Massengill:

Which provider, which is working for that day, on their account.

Nathan Baugh:

1:13:57
Mandi, are you, how are you tracking the time of employees that might just be responsible for specimen collection?

Mandy Shelast:

1:14:08
John, that's a good question that you bring up and thanks Nathan. Right, now, we're not using any of the funds to support staff salaries. However, we are allocating out the time that our teams are going out and collecting swab by different paths centers that we just set up a different cost center within our timekeeping system. And then we'll allocate them with dollar hours over there for whichever staff member is helping out with testing, and, you know, that's variable, depending on which one of an RHC that is that we could definitely breakout hours if we needed to. We've just chosen not to use that for labor costs at this time.

Nathan Baugh:

1:14:45
But, I will just note that labor cost is an appropriate use of the funds, is one of the things highlighted. So, with that, I'm going to go ahead and close out the webinar. I'm sorry, we didn't

get to everyone's question, but as you can see on your screen, hopefully you guys can see my screen.

1:15:07
You're free to e-mail myself, Bill or are our partners over at NOSORH questions you have about this covid testing fund and covid Testing in general?

1:15:21
I'd like to thank everyone for attending today's webinar, especially our speakers, doctor Keith Davis from the ...

1:15:28
Medical Center, Mandy Shelast, again, from Aspirus Health System And William Massengill from the Benson Area Medical Center for their presentations, as well as the Federal Office of Rural Health Policy for sponsoring the RHC TA webinar series.

1:15:48
Again, we encourage others who may be interested, to register for the webinar series, that ... dot org, or the RHIB Hub website. In addition, we welcome you to e-mail us, particularly me Nathan Baugh, with your thoughts and suggestions for future topics.

1:16:06
And, if, hey, if you want to be a speaker, you can volunteer as well at nathan.baugh@narhc.org

1:16:15
Just be sure to put RHC webinar topic in the e-mail subject line. For our CRHCP

1:16:23
Professional guides are certified, rural health clinic professionals, the CEU code is J, W 9 4 X Y.

1:16:38
I was going to use code words for that, but those are difficult.

1:16:41
Let's not like alpha and beta and things like that.

1:16:44
So it's, again, it's just J, W 94 X Y, J W 9 4 X Y, when we schedule the next webinar a notice will be sent by e-mail to those who have registered for the webinar series with the details.

1:17:01
Thank you for your participation, and this concludes today's webinar.

1:17:11
Thank you, everyone.

1:17:14
Be well.