Title: A national study of community health centers' readiness to address COVID-19

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Abstract

Background: The coronavirus disease 2019 (COVID-19) outbreak, a public health emergency of international concern, poses a serious health risk, particularly for older adults and persons with underlying chronic medical conditions. Community health centers (CHCs) serve as the patient medical home for populations that are disproportionately more susceptible to COVID-19; yet, there is a lack of understanding of the current efforts in place by CHCs working to prepare for and respond to the current pandemic.

Methods: We conducted a sequential explanatory mixed methods approach, using a comprehensive cross-sectional survey and focus groups with physicians, nurses, medical support staff, and administrative leaders to understand the needs and current efforts in place by CHCs across the U.S. working to prepare for and respond to COVID-19. We applied the transcript-based analysis approach to the focus group data and derived themes using the constant comparative method.

Results: Survey respondents (n=234; 19% response rate) identified guidance regarding COVID-19 infection prevention and control (76%), safety precautions (72%), and screening, diagnostic testing, and management of patients (66%) as their major educational needs. Findings from the focus groups (n=39) highlighted five key themes relevant to foundational aspects of readiness: leadership, resources, workforce capacity, communication, and formal policies and procedures.

Discussion and Conclusion: The COVID-19 pandemic has exacerbated longstanding capacity issues that CHCs have faced, making it challenging for these safety-net practices to adequately respond to the current disease outbreak. Policies that promote greater investment in CHCs may

47 strengthen these systems to better meet the needs of the most vulnerable members of society, and
48 thereby, help flatten the curve.

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INTRODUCTION

On January 30, 2020, the World Health Organization (WHO) described the coronavirus disease 2019 (COVID-19) outbreak as a public health emergency of international concern.[1] Less than six weeks later, WHO publicly characterized the novel respiratory disease as a pandemic.[2] The United States Federal administration's actions followed suit by initially declaring a public health emergency on January 31, 2020, then on March 13, 2020, officially declaring a national emergency. While the Centers for Disease Control and Prevention (CDC) have noted that the U.S. is currently in the initiation phases with some states now in the acceleration phase, emerging evidence shows that some people are at higher risk than others of becoming very ill from COVID-19, including older adults and persons with chronic medical conditions such as heart disease, diabetes, and lung disease.[3]

For over 50 years, community health centers (CHCs) in the U.S., through funding from the U.S. Health Resources and Services Administration (HRSA), have functioned as the nation's primary care backbone for the medically underserved, and have been at the forefront of serving the most vulnerable members of society. CHCs provide essential medical, behavioral health, and dental care to patients who disproportionally suffer from chronic health challenges and have poorer health outcomes.[4] Twenty-eight million people nationwide (1 in 12) rely on CHCs for affordable and accessible primary care, including 1 in 5 rural residents, 9 out of 10 persons living in poverty or near poverty, more than 1.2 million persons experiencing homelessness, and over 385,000 veterans. [5] Moreover, CHC patients are more likely to be unemployed and uninsured compared to the general low-income population in the U.S.[4]

In addition to meeting the comprehensive primary care needs of the country's medically underserved populations, CHCs play a vital role in supporting the U.S. public health system, and have demonstrated success in addressing other public health challenges. For example, in 2018, as part of the nation's effort to end the HIV epidemic, health centers provided over 2.4 million HIV tests to more than 2 million patients and treated 1 in 6 patients diagnosed with HIV nationally. In the same year, CHCs screened and identified nearly 1.1 million people for substance use disorder and has, since 2017, provided medication-assisted treatment to nearly 95,000 patients nationwide, an increase of 143%.[5] Nonetheless, even in the midst of current emergency preparedness and response efforts to the COVID-19 pandemic at the local, state, and national levels, there is a lack of understanding about the extent to which these efforts are meeting the needs of safety net practices, their workforce, and subsequently, their patients, who are most susceptible to COVID-19 and its negative health and social-related sequelae. Additionally, it is important to frame this work in the baseline realities of safety-net practices by recognizing that community health centers were already under-resourced even prior to the current pandemic, which exacerbates the current stressors. The purpose of this mixed methods assessment was to understand CHCs' needs and readiness to address COVID-19. To our knowledge, this is the first and only national, multisite study of its kind.

METHODS

Study Design

We used a sequential explanatory mixed methods approach to understand the needs and current efforts in place by primary care staff and practices across the U.S. working to effectively

prepare for COVID-19. Findings from the baseline cross-sectional survey were subsequently used to develop the interview guide for the focus groups.

Survey Development

We developed a web-based, cross-sectional survey regarding organizational and individual staff needs, and best practices currently in place to prepare for and prevent spread of COVID-19 [Appendix 1]. Four items were selected for the survey, which directly reflect the domains of interest for healthcare professionals that were outlined on the CDC resource page at the time that this study was being designed.[6] We subsequently pilot-tested the survey with six administrators and clinicians at Community Health Center, Inc. (CHCI) who were representative of the target population to provide input on the initial survey, particularly the wording, ordering, and administrative burden of completing the survey. Improvements were made to the survey and were reflected in the finalized administered survey. Registrants had the opportunity to complete the survey on SurveyMonkey beginning on March 3rd, 2020 through March 6th, 2020.

Survey Administration

The survey was administered to 1259 health workers in the United States who registered for a special Weitzman Institute Project ECHO. Registrants represented 730 health organizations from 49 states (Idaho not represented), Washington D.C., Puerto Rico, and Guam. Of those registrants invited to participate, 240 people completed this survey, yielding a response rate of 19%.

Focus Group Schedule Development

The last question of the survey we administered asked respondents if they would be willing to participate in a focus group regarding community health centers' response to COVID-

19. Of the 240 people who completed the survey, 131 expressed interest in participating in the focus groups. These 131 survey respondents were subsequently invited via email to sign up for a focus group to provide more in-depth responses regarding organizational and individual readiness. Participants were offered to the opportunity to attend one of seven virtual focus groups using the Zoom video conferencing platform. We enrolled a maximum of ten participants per focus group.

Focus Group Administration

Of those who completed the survey, a convenience sample of 39 participants agreed to attend one of a series of hour-long focus groups held within one week of the initial survey being administered. Three of the 39 participants participated in the focus group but did not complete a survey. These 3 individuals were forwarded the request from a colleague within their organization who was invited to the focus group. Focus groups have been identified as an economical, fast, and efficient method for obtaining data from multiple participants, thereby potentially increasing the overall number of participants in a given qualitative study.[7,8] The focus groups covered three domains based on a priori discussions with key informants (e.g., CHC providers, administrators): 1) organizational and staff strengths and gaps in COVID-19 preparedness, 2) psychosocial impact of COVID-19 on health workers and patients, and 3) role of technology, particularly telehealth [Appendix 2]. The focus group facilitator closely followed the interview protocol in an effort to minimize potential interviewer bias. All focus group sessions were audio-recorded. Focus group attendance ranged from 5-7 participants in each session. The current report focuses on data derived from the first two domains.

Data Analysis

The research team applied descriptive statistics to analyze the survey data and determine frequency of endorsing the needs outlined in the survey. The research team subsequently applied the transcript-based analysis approach to the focus group data, which represents the most rigorous model of analyzing the data;[9] Two trained coders independently applied an iterative coding process to analyze the interviews and derive themes using the constant comparative method.[10] Consensus meetings were used to come to agreement on final codes, definitions, and exemplars to be included. This study was approved by the CHCI Institutional Review Board.

RESULTS

We observed a 19% response rate as the survey was completed by 240 primary care employees from 201 organizations across 44 states, the District of Columbia, and Puerto Rico [Table 1]. 6 participants were excluded from the initial survey due to incomplete data, leaving 234 participants in the study. The majority of respondents (59%) held administrative leadership roles at their respective agencies, while the remainder of the participants served in patient-facing roles as physicians (8%), nurses (13%), and medical support staff (20%). Over a third (38%) of the participants came from practices in the Northeast region of the country, with the rest of respondents coming from the West (19%), South (19%), and Midwest (23%) regions, and minor representation from Puerto Rico (1%).

Findings from the survey revealed that the top educational and resource needs endorsed by participants according to their respective job titles include guidance regarding COVID-19 infection prevention and control (76%), safety precautions for patient-facing healthcare personnel (72%), and screening, diagnostic testing, and management of patients (66%).

Additionally, 199 out of 234 respondents (85.0%) indicated the need for safety planning checklists, including policies and procedures for emergency preparedness as their respective practices either do not currently have these plans in place, or participants are largely unaware of such resources if they do exist [Table 2]. Analysis of the focus group data revealed five overarching themes relevant to foundational aspects of readiness including leadership, resources, workforce capacity, communication, and formal policies and procedures [Table 3].

Leadership

Leadership, defined as providing general oversight of the practice and/or team(s), was described as an important aspect of organizational and individual readiness. Some respondents noted that decision making was challenging when health center leaders received conflicting guidance and recommendations provided by leading government and public health authorities. Additionally, there were multiple descriptions about the need for unity and alignment among senior leadership, including among administrative and clinical senior leaders. Conversely, there were concerns raised about both existing and potential disagreement among leadership and its impact on health center's decision making during public health crises such as the current pandemic. For example, participants described competing priorities with regards to health centers' bottom line and financial well-being, with the health and safety of staff and patients. Others also commented on the need for leadership to promote clarity in defining roles of different healthcare team members.

Resources

Across respondents, there was resounding concern over CHCs having limited resources, specifically testing supplies, personal protective equipment (PPE), and negative pressure rooms.

Respondents discussed not being able to meet demand from patients for COVID-19 testing. Similarly, respondents admitted to challenges with staff not having access to N95 face masks, but also not having undergone fit testing or training on proper fitting, wearing, and removal of masks as this was not deemed to be a priority until the current situation arose. In addition, respondents expressed challenges with government support and issuing of supplies not reaching CHCs. Lastly, ethical issues of staff stealing health center supplies for personal use was also raised, and the ramifications that these actions have on the health and safety of health center staff and patients.

Workforce Capacity

Participants noted the acute and chronic challenge of workforce capacity, defined as sufficient staffing levels to carry out necessary work processes. Comments were made noting that CHCs are having to quickly focus on and prioritize COVID-19, but are having to do so with limited staffing capacity. Respondents noted how the current pandemic has contributed to workforce burnout by adding to the already demanding daily tasks that CHC staff have, particularly in serving large patient panels in the midst of other health center closures, and medically complex patients with limited resources. In addition, participants also pointed out the workforce shortage and the subsequent strain on the remaining healthcare workforce when colleagues have to handle personal responsibilities.

Communication

There were a range of responses regarding level of readiness, as well as needs around communication, defined by exchange of information. Several respondents described having comprehensive communication strategies across their respective practices that involve multiple

modalities such as an internal command center, email, and, text messaging. In contrast, others admitted to major gaps in their internal communications and challenges with ensuring real-time dissemination of accurate information to both staff and patients. Respondents discussed the challenges of competing with and overcoming misinformation that is spread through mass media, which respondents have found to invoke fear, panic, and confusion among their patients, as well as determining how to communicate with hard-to-reach patient populations such as the elderly population who may be less technologically savvy. In other words, respondents agreed that there is not only a dire need to improve and ensure staff have a means of rapidly communicating with each other, but there is also a shared sense of responsibility to be able to communicate with patients and communities to ensure they are well-informed and equipped with timely and accurate information.

Formal Policies and Procedures

Similar to the comments regarding communications, respondents described varying degrees of readiness to implement and execute policies and procedures specific to the current pandemic. While respondents for the most part, noted having emergency preparedness protocols in place, they described major challenges in complying with a standard set of policies and procedures. Limited supplies made it difficult to be compliant with protocols; furthermore, the rapidly evolving nature of the current pandemic and the accompanying changes in guidance provided by government and public health authorities makes it difficult for CHCs to implement the most appropriate protocols. Nonetheless, some respondents provided details about how their respective practices have risen to the present-day challenge, and implemented new procedures in

response to COVID-19. Respondents shared some examples of additional safety precautions and alternatives for meeting demand including triaging patients outside the clinical buildings, as well as leveraging community health workers to conduct home visits particularly to high-need, hard-to-reach patients.

DISCUSSION AND CONCLUSION

Findings from both the survey and focus groups highlight the significant need for knowledge and capacity development, especially in the area of infection control policies and procedure. While respondents noted a need for clinical information about testing and management of patients, their responses suggest an even greater need for guidance on carrying out proper infection control protocols. One prior study assessing readiness to tackle an influenza pandemic found that most health centers lacked the capacity to effectively implement needed infection control policies.[11] For the current pandemic, it is unclear, based on these findings, whether the problem is a lack of appropriate policies and procedures or a lack of expertise and knowledge on how to properly implement and follow them. Eighty-five percent of respondents endorsed a need for tools such as safety checklists and formal policies to follow. However, focus group participants suggested that the need was less about the having the policies and more about limited expertise or preparation to follow them. One respondent noted that fit testing for N95 masks had never been done, despite it being mandated in their policy. This finding is consistent with a study conducted prior to the COVID-19 pandemic, which found that CHCs were less likely than local health departments to have engaged in actual preparedness planning such as conducting drills.[12] Immediate attention is needed to address these deficiencies, in the form of educational tools and resources on proper infection control procedures.

In addition to the more universal concerns about lack of testing and personal protective equipment, these findings highlight the special challenge posed by lack of staffing resources in CHCs. Recruiting and retaining staff in rural and other medically underserved practice locations has burdened health centers long before the pandemic.[13] Conversely, COVID-19 will inordinately affect the most vulnerable segments of the population, including those with the fewest resources to deal with its medical and financial consequences. Low staffing ratios and unfilled positions leave little in the way of "surge capacity" needed to address the expected increase in demand for services. Responses from the focus groups clearly reflected the difficulty imposed on an already stretched, understaffed workforce in pivoting to rapidly address the expected surge in demand from patients related to the pandemic.

The limitations of the current study should be noted. First, the use of convenience sampling methods in this study may limit the generalizability of the findings as the perspectives provided by the participants here may not be representative of CHCs and their healthcare teams as a whole. Similarly, the majority of focus group participants were from either the Northeast or Midwest regions of the country, and serve in administrative leadership roles, which may not be representative of the experiences of their regional and professional counterparts. Additionally, the survey did not cover an economic or finance-related questions. Lastly, the study was not powered to detect differences in identified needs and responses based on professional role, including between administrative and clinical staff.

Nonetheless, the findings presented here offer a first look at the nature of this challenge and the needs that must be addressed to ensure that CHCs are able to provide an effective response to this growing public health emergency. Thus, the findings from this study have

several immediate and long-term implications on policy, practice, and research. The COVID-19 pandemic is occurring at a time when CHCs nationwide are experiencing great economic uncertainty with hiring freezes, layoffs, and reduced patient care services, which can be exacerbated by the current public health crisis. Consequently, greater Federal financial support for CHCs is needed to ensure these practices have the capacity to continue serving the most vulnerable members of society, thereby helping relieve the stress on hospitals and flatten the spread of COVID-19.

Additionally, ensuring that CHCs are adequately staffed and resourced is of particular urgency during the current pandemic. There is the potential for an influx of healthcare utilization given the significant economic impact of COVID-19 and subsequent increase in persons becoming unemployed or uninsured, complicated by the fact that there are members of the U.S. workforce with public-facing jobs that do not have remote or teleworking options and consequently, are at higher risk for exposure. Lastly, the current pandemic presents an opportunity for learning and improvement. Future research regarding lessons learned during the current outbreak can help improve our healthcare system's preparedness for addressing future disease outbreaks, and strengthen the capacity of CHCs to care for individuals and communities that are both most at-risk and in need.

In conclusion, this paper explored the readiness of community health centers to face issues related to COVID-19. While the focus was on this new pandemic, the findings have broad relevance to healthcare in the U.S. not only as it relates to the current pandemic, but with regards to future public health emergencies and crises. Community health centers comprise the backbone of care to marginalized, vulnerable populations including the poor, racial/ethnic minorities, the

homeless, migrant farm workers, HIV, and substance users, to name only a few. Their readiness, or lack thereof, to provide healthcare and adapt to challenges from the current and future pandemics is fundamental to our ability as a nation to ensure that all people have access to the core healthcare services they need. As this paper points out, health centers were not ready for COVID-19. Surveys have suggested that care delivery by FQHCs has shrunk by nearly half. The impact of this lack of readiness is apparent in the halting, ineffective response to the epidemic and its disproportionate impact on the most vulnerable people. Therefore, addressing the needs and enhancing the CHCs' capacity may strengthen the health care for the most vulnerable members of society, and thereby, help flatten the curve.

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Table 1. Characteristics of participants who completed surveys between March 3, 2020 and March 6, 2020 and who participated in focus groups between March 10, 2020 and March 17, 2020.

	Survey Respondents (n=234) n (%)	Focus Group Respondents (n=39) n (%)
Role		
Administrative Leadership	139 (59%)	18 (46%)
Physician	19 (8%)	9 (23%)
Nurse	30 (13%)	4 (10%)
Medical Support Staff	46 (20%)	8 (21%)
Region		
Region 1 Northeast	90 (38%)	13 (33%)
Region 2 Midwest	53 (23%)	12 (31%)
Region 3 South	44 (19%)	5 (13%)
Region 4 West	44 (19%)	8 (20%)
Puerto Rico	3 (1%)	1 (3%)

Table 2. Top educational and resource needs endorsed by participants who completed surveys between March 3, 2020 and March 6, 2020.

	Survey Respondents (n=234) n (%)			
	COVID-19 infection prevention and control	*Screening, diagnostic testing, and management of patients*	*Safety precautions for patient-facing healthcare personnel*	*Safety planning checklists, including policies and procedures for emergency preparedness*
Role				
Administrative Leadership	107 (46%)	90 (38%)	99 (42%)	116 (50%)
Physician	15 (6%)	14 (6%)	14 (6%)	17 (7%)
Nurse	22 (9%)	21 (9%)	18 (8%)	24 (10%)
Support Staff	35 (15%)	30 (13%)	37 (16%)	42 (18%)
Region				
Northeast	72 (31%)	57 (24%)	67 (30%)	77 (33%)
Midwest	41 (18%)	38 (16%)	37 (16%)	44 (19%)
South	32 (14%)	29 (12%)	32 (14%)	36 (15%)
West	33 (14%)	30 (13%)	29 (12%)	39 (17%)

Puerto Rico	1 (0.4%)	1 (0.4%)	3 (1%)	3 (1%)

Table 3. Focus Group Key Themes related to Organizational Readiness to Address COVID-19.

Theme	Sample Quotes
Leadership	*One of the barrier is conflicting guidance between Delaware Department of Health, CDC, and World Health Organization, which creates internal conflicts since some leaders will follow one, and the others follow another. (Director of Quality Improvement, Delaware)* *Another barrier is with our finance administrative folks who think from an economic standpoint and if we need to close clinics and let people work from home, they are thinking about a loss of revenue, which is in opposition with the clinical people who are more concerned about the safety of our staffs and patients. (Chief Medical Officer, Illinois)* *Definitely challenging for us to make sure that leadership is on the same page because our executive directors and medical directors have had different opinions at time so it is really important for us to come together quickly making sure we are considering the health and wellbeing of our staffs and patients, and for our financial results, how much to charge for telehealth visit. (Practice Manager, Ohio)*

Resources	*Everybody wants testing and we don't have the capacity to test everybody. That's my biggest concern. Because we were in the rural side of the state, we just got the testing materials this week. The fact is everyone with a sniffle want to get it tested and we don't have the capacity to do that. (Director of Training and Compliance, Washington)*
	One of the main issue we are having is geographic spread we have across the state. We have clinics that are very small, 2-3 rooms and one solo provider or clinician. If we have 1 or 2 to the patients that need to be isolated, that creates a significant reduction in the way that we care for patients. (Vice President of Clinical Affairs, New Mexico)
	The biggest problem we are having is not having enough PPE. We are running out of masks, and I also know that we are running out of all of the necessary wipes and everything although we have a plan to go to like bleaching water solution for that. Even though the California Governor is issuing a million supplies, they are not falling through the system to get to community health centers. (Chief Medical Officer, California)
	We noticed some of our masks disappear, so we have to put out a notice that even though we know you want to protect yourself and your family, but you

	cannot take health center's properties and we will take action if anybody do that. (Primary Care Provider, New York)
Workforce Capacity	*I think it is a lot more stressed for us because we are able to see the deficits that we have in our system and those deficits are rapidly progressing. All of us here are very stressed out and we are adding that on top of the things that we do already every day. (Clinical Educator, Illinois)*
	The other complexity is another health center near us has significant number of homeless population in the community, and that center closed in December. So, we still have many of those folks that have not established primary care elsewhere and then they may be showing up in our lobby or at our doorway requesting assistance without having any other route. (Director of Nursing, Michigan)
	In reality, most of my NPs have babies and multiple kids. When we start thinking about quarantine and women dominated workforce like I have, it's a huge worry for me…. And other organizations they just laying workers off and I know I have lots of people who need their pay check and so what are the consequences, how do we keep the money flow so that my employees don't become part of the economic ripple effect ends up impacting the personal life. (Chief Executive Officer, Ohio)

Communication	*We never really get communication out to our staffs in a desired time frame. We have a lot of providers, a lot of staffs, taking a word of media, from family and communities, rather than realizing that we are the experts in healthcare. (Director of Training and Compliance, Washington)*
	We implemented basically for the administration we do a daily brief update on COVID-19, so we are able to make sure that we are standardizing every site here. So, we might have a clinical center director who really goes into details and someone from another site who doesn't have a clinical background they might give different messages so we are using our daily brief to actually standardized message to everyone across the organization and I think that's been very helpful. (Chief Executive Officer, Ohio)
	Our role as an educator is pretty massive in educating our communities, not all of them are medically educated and so they depend on us for COVID-19 information. We are going to look at how we reach out to our communities differently in the future as well. (Community Health Worker, Michigan)
	I think communication to the patients, some folks are not understanding fully with what to do. They come in and they say that they have been in contact with someone who tested positive, and they have no symptoms and

	they are confused where they can get tested. So, it has been difficult to try to explain the folks the processes and hope that there is the larger testing system come in place that we can all use. I think that's is the biggest piece making sure that we are educated and the public are educated as well, so giving that consistency across the board has been a challenge. (Director of Facilities, Illinois)
Formal Policies and Procedures	*We have a great big binder that has everything everyone wants to know and quite honestly it didn't help much as all in the preparation for this. So, having plans and policies sit on the shelves, I think we probably did ours, you know ten years ago and you know with everything else we all working on become less of the priority. So that we have to plan which really not much help, but we have to do everything from inventory and finding out where all our supplies were, start pretty much from scratch. (Director of Clinical Best Practice and Education, New York)*
	I am really struggling to find a written triage protocol to help providers and nurses how to decide in a situation like this. It seems like we are having to update our policies daily because the situation continues to change. And we also have hard time pinning down the policies about testing. As of last week, we didn't have any commercially available testing, so we referred and directed anyone to health department. Today, we got a phone call from

Texas health department that said not to send anyone to the health department. It's like every two days, we need to rewrite our protocols. (Associate Medical Director, Texas)

Starting next week, in order to keep our medical staffs and other patients healthy, we have established a triage unit outside the buildings in order to detect any symptoms before they get to the regular population. (Health Educator, Puerto Rico)

We are not doing as many face to face visits, and employees are going to do home visits. So we are looking combined pharmacy delivering meds, home visits, and having maybe medical assistants or community outreach workers going to some of the high need people who don't have the smart phone capability. (Chief Executive Officer, Georgia)
