HEALTH CENTER STORIES:
HANDLING DISEASE OUTBREAKS

Providing first-hand accounts of addressing disease outbreaks in the health center setting

LifeSpring Health Systems

In a small town in Scott County, Indiana, public health officials took notice of an emerging outbreak. While Austin, Indiana had only 5 HIV infections diagnosed between 2004 and 2013, 17 new cases were diagnosed between November 2014 and January 2015. Beth Keeney from LifeSpring Health Systems was right in the middle of the public health response to this emergency. In this ***Health Center Story****, Keeney reflects on the experience of being front-line in helping Austin address and recover from its HIV outbreak.*

Q: What happened in Austin, Indiana and what was LifeSpring's role throughout the outbreak?

A: Our county health department called my CEO about an HIV outbreak related to intravenous substance abuse in Austin, Indiana in December 2014. Austin is a rural, conservative town and pretty isolated. For example, we have had an office just 3 miles outside of Austin for 30 years, but we never had Austin residents as patients. At the time of the outbreak, we were a community mental health center in the midst of applying to become an FQHC, and the county called upon us to provide addiction treatment. To be honest, initially I didn't think that there was truly an outbreak situation because communities like Austin are generally not at high risk for HIV. But after our first meeting, we realized that there was a huge problem going on.

A public health emergency was declared in late March, 2015. As a first response to the outbreak, the state health department rented an empty building in Austin for 90 days and set up a "one-stop shop," where people could get almost any service under one roof. Residents could enroll in health insurance; we had people from the Department of Motor Vehicles so folks could get drivers licenses; we had Department of Children's Services staff to address issues of child abuse and neglect; we had syringe exchange services and HIV and Hepatitis C testing; and of course, medical

Beth Keeney, MBA

Senior Vice President for Community Health Initiatives & Chief Operating Officer of Primary Care Services at Life Spring

Health Center: LifeSpring Health System, Jeffersonville, IN

Number of Years with LifeSpring: 10

Number of sites: 10 mental health centers and 3 FQHCs; planning to open a 4th

Setting: Suburban and rural

Number of clients served: 8,500 in 2017

"In the middle of a public health emergency, nobody is going to do it alone."

care and behavioral health care. We provided the addiction treatment and counseling services.

As soon as the one-stop shop began, we started thinking of a long-term solution, because we all knew that the one-stop shop was not permanent. There were a lot of groups and organizations that came in during the outbreak, and we knew they were not going to stay. So we focused on getting

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a permanent location and just strengthening our relationships with our community partners, like the health department, the hospital and some of the prevention programs in the community.

By the summer, after this acute rush of services, providers, and resources, we saw a sharp decline in new HIV diagnoses. By then, we had moved into our new building as a newly certified FQHC in Austin. And at this point, we weren't providing an emergency response anymore. It was just the new normal. At some point, it ceases being an emergency, and it just becomes the way health care in that community looks. People are working hard to make Austin a better place, and there are a number of groups who are truly committed to the recovery of Austin.

Q: What groups were involved and who was coordinating the emergency response effort?

A: The State Department of Health was the coordinating entity. There were so many other players: the State Division of Mental Health and Addiction, Centers for Disease Control & Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), our local hospital, the county health department, and other local providers. Our role in this emergency response effort was very clear because we were asked to do pretty specific things. We had a lot of support, particularly from the CDC and the State Department of Health.

Q: What advice do you have for health centers looking to bolster their relationships with potential partners?

A: My advice would be just to call and share what you're doing in the community and ask them how you can be involved in emergency preparedness planning. For our health department, I called them one day, told them about our new clinic and asked if I could come and talk to their staff about it. Out of that initial call, a really great partnership has grown. We send nurses to their syringe service program and they share their mobile clinic with us.

Q: How did you staff the new "one-stop shop" clinic while continuing to run and staff your other clinics?

A: Initially we thought that we could staff this site with bachelor's level case managers, but the patients were very high acuity. We realized we needed our therapists, which challenged the staffing at our other clinics. We stretched our therapists. Managers, who may not have typically had a full caseload, saw more patients, and part-time staff picked up hours.

We just made it work. That was challenging from a staffing perspective, but also financially, because we were never reimbursed. And that was a lot of lost revenue over 3 months to pull that many staff off of billing. It was the right thing to do, it was an important thing for the community and certainly we would do it again tomorrow if that's what needed to be done. But it was very challenging.

Q: Were your staff trained in HIV outbreak protocols?

A: The CDC came and trained our providers on HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) protocols and sent us all of their materials on that, which we still use. The staff that we sent out for the behavioral health response were well trained in trauma and trauma informed care, which was critical for this response. Our infection control nurse also trained them in HIV and viral hepatitis, going beyond the annual infectious disease training module completed annually. Some staff also went to an intensive day-long HIV course. Currently, on the primary care side, we train all new medical staff on PrEP and PEP protocols, so that they're doing HIV prevention and so that anybody can get HIV preventative medication at any of our locations, not just in Austin.

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Q: Did your emergency preparedness plan prepare you for this outbreak?

A: We did have emergency preparedness plans in place, but at that time, they did not include epidemics. Our plans have changed, not only in response to what we learned in the HIV outbreak, but also due to new CMS requirements and because they needed to be updated in general.

Q: What was most difficult part about responding to this outbreak?

A: Throughout the emergency response, LifeSpring was also applying for FQHC accreditation and looking for a permanent location in Austin. It was very challenging to try to satisfy all of the different stakeholders that were at the table. At the end of the day, we realized that we couldn't make everyone happy and that we had to move forward with what we believed to be in the best interest of the population we were serving. It was a relief to let go of the expectation that we had to satisfy everyone, and once we did, we could move forward. We could devote all of our resources to our main goal-helping the people of Austin.

Q: Looking back, what do you think LifeSpring did well in response to this outbreak?

A: I think that we responded quickly, decisively, and adapted well to a challenging environment. And that was really tricky. But I think we did that well because, as an organization, we've been providing public healthcare since 1964. Navigating difficult situations is something that we've been doing for decades. We also have an incredible executive management team and a great board of directors

that really supported what we were doing instead of saying that we were losing money sending our therapists to the pop-up clinic. Everybody recognized that this was a true public health emergency that we needed to respond to.

We also had staff at almost every meeting and event related to the outbreak. The State Department of Health kept a really good log of everything that was going on, which allowed us to stay connected. Physically sharing space also helped this connection.

Lastly, we didn't oversell what we could do and we were pretty clear about what our limitations were, with ourselves and with our partners. For example, we never said we could definitely get somebody in for detox in a week if we knew our waiting list was six weeks. In fact, all of the partners were brutally honest with each other. If they had concerns, they shared them. If we had concerns, we shared them. There wasn't anything to be gained from playing things close to the vest, so to speak.

Because we were working side by side with each other, there was enough trust that we were all working towards the same goal. In the middle of a public health emergency, nobody is going to do it alone. ■

**This interview has been edited and condensed.*

Leveraging Health Centers in Public Health Preparedness

To better understand how health centers can assist during a disease outbreak, R&E Group at PHMC conducted a comprehensive needs assessment of health centers in 2017. The assessment included a nationwide poll of health centers and key informant interviews with health center leadership. It identified health centers' current capacity, barriers health centers face, strategies to improve preparedness capacity, and training needs. The nationwide poll was sent to 1,376 health centers, and a representative sample of nearly 400 responded.

Health Center Stories was developed by Public Health Management Corporation (PHMC), the National Nurse-Led Care Consortium (NNCC), a PHMC affiliate, and the National Network of Public Health Institutes, through Cooperative Agreement #CDC-RFA-OT13-1302 with the Centers for Disease Control and Prevention. Together, these organizations and other strategic partners are leveraging community health centers and clinics to improve national public health preparedness efforts. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Key findings from the nationwide poll

90% of health centers have a written emergency management plan; 75% cover outbreaks

25% said they were "almost or completely ready" to respond to an outbreak

About 50% have participated in or conducted exercises on preparedness

About 45% have a documented role in emergency preparedness plans

Top training needs: staff training in response to pandemics, compliance with CMS requirements, exercises and materials relevant to health centers, staffing during emergencies, acquiring necessary supplies, understanding state-level policies, and understanding the health center role during a pandemic

In response to the identified training needs, NNCC hosted a 4-part Emergency Preparedness Webinar Series on building a culture of preparedness in the health center setting. The webinars explained the requirements of the CMS Emergency Preparedness Final Rule; addressed bolstering health center staff capacity and readiness; and explored ways of advancing the health center role in local emergency response efforts. Visit Emergency Preparedness at NNCC's website, nurseledcare.org, for webinar recordings and presentation slides.

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