MMS Member Forum Summary

MMS Virtual Town Hall Forum
Practice Operations and Delivering Patient Care During COVID-19
Tuesday May 26th, 2020

On Tuesday May 26th, the Massachusetts Medical Society (MMS) hosted a ninety-minute Virtual Town Hall Forum for members to engage with Medical Society leadership and to ask questions regarding Practice Operations and Delivering Patient Care During COVID-19. Dr. Maryanne Bombaugh guided the forum with fellow officers, Drs. David Rosman, President-elect, and Carole Allen, Vice-President and MMS Executive Vice-President, Lois Cornell.

Speakers included Lauren Peters, Undersecretary of Health Policy with the Executive Office of Health and Human Services, Dr. Ben Kruskal, Medical Director at New England Quality Care Alliance, and Dr. Michael Sheehy, Chief of Population Health and Analytics at Reliant Medical Group. Additional faculty included Amanda Cassel Kraft, Deputy Medical Director with the Executive Office of Health and Human Services, Dr. Ryan Schwarz, Director of Policy for Accountable Care with the Executive Office of Health and Human Services, Dr. Kate Fillo, Director of Clinical Quality Improvement at the Massachusetts Department of Health, and Torey McNamara, Director of Policy and Regulatory Affairs at the Massachusetts Department of Public Health. The moderator for the evening was Dr. Barbara Spivak, president and chairperson of the board of the Mount Auburn Cambridge Independent Practice Association and Chair of the MMS Committee on the Quality of Medical Practice.

Forum presentations and summary of highlights

To view the slide deck containing the slides from each of the presentations below, please click here.

Forum Presenter 1: Lauren Peters

The goal of Ms. Peters’ presentation was to provide members with an overview of the state's approach for phase one reopening as it applies to the healthcare system. While the approach and guidance are largely the same for both hospitals and other non-hospital providers, there are some slight nuances. For a copy of the slides that accompanied this presentation, please click here. Ms. Peters focused on non-hospital providers but also made sure to highlight areas of key distinction. In April the governor established the Reopening Advisory Board, comprised of representatives from the business community, public health officials, and municipal leaders to inform the state's approach to reopening. The proposed plan, which was released on May 18th, reflects the input of a diverse spectrum of businesses, organizations, and constituencies, including the Mass
Medical Society, and one that is key data driven. Ms. Peters noted that key public health metrics will ultimately determine if and when it is appropriate to proceed through reopening phases. These key public metrics include the COVID 19 positive test rates, mortality rates, hospitalization rates, health care system readiness, testing capacity, and contact tracing capabilities.

Ms. Peters noted that the approach to re-opening health care services warranted an inherently unique set of discussions and considerations from the conversations that were happening with other industries and sectors. On one hand, much of the healthcare system never closed down, with hospitals, nursing homes, and other residential care programs operating at full capacity. She noted that the healthcare industry has seen a large increase in telehealth utilization, particularly for behavioral health services, which is a really positive thing. On the other hand, she noted that with the pause in elective care, compounded by the general fear that much of the public has of seeking medical services during this time, a significant portion of care has been deferred, which has resulted in a steep decrease in vaccinations and the worsening of conditions that have turned emergent as a result of delayed medical attention. Ms. Peters explained that in trying to balance overall system demands and capacity with access to these necessary medical services and care, the stated goal for phase 1 of re-opening is to allow high priority preventative care and non-emergency procedures that have been deferred, but are now at risk of becoming emergent, to resume while preserving sufficient hospital capacity for continued COVID 19 treatment.

Ms. Peters went on to explain that the approach to phase 1 re-opening is comprised of four key components. The first component, initiating phase one, is contingent on sufficient statewide hospital capacity, and that threshold has currently been met. The second component involves providers attesting to their ability to meet certain public health and safety criteria. If the above two are met, the third component is that the provider may resume a limited set of in-person services that, based on the provider's clinical judgment, are high-priority preventative care, including all pediatric care, such as vaccines and well-child visits, as well as chronic disease care for high-risk patients. In addition, this third component includes resuming urgent procedures or services that cannot be delivered remotely and would lead to high-risk or significant worsening of the patient's condition if deferred. The final fourth component is the expectation that telehealth should continue whenever clinically appropriate, recognizing that there are some limitations on both the provider and patient side.

Ms. Peters then went on to lay out the state's general reopening framework, and the roadmap for how the state is approaching phase one, and beyond. She explained that the state is thinking about this approach in three buckets. The first bucket “services currently operating”, includes hospitals, nursing facilities, and other facilities that never really ceased operations. In future phases, the state will continue to monitor and address certain restrictions and limitations that have been placed, such as visitation. Bucket two, “Delayed/Deferred Services” has been the focus of the state’s Phase 1 discussions. Ms. Peters noted that the state is starting with a limited subset of services and procedures. Throughout phase one, the state will continue to monitor progress and the impact on the healthcare system to inform decisions for future phases, including what additional services should be resuming and what other programs should be able to resume, as well as when, and under what conditions. Finally, bucket three “Services Delivered Remotely”, represents the set of services that can be delivered remotely or through telehealth that, where clinically appropriate, should continue to the extent possible.

Ms. Peters also noted that phase one reopening was contingent on sufficient statewide hospital capacity being met and maintained through May 25th. Specifically, the system could not move into phase one until it had at

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least 30% staffed adult ICU, including surge bed capacity available, and at least 30% total adult inpatient bed capacity available. This threshold was met and maintained through May 25th, 2020 allowing providers to move into phase one so long as they meet a certain set of criteria.

Finally, Ms. Peters outlined and explained the set of criteria that providers must meet and attest to in order to move into Phase 1. **First,** providers need to attest to having an adequate PPE supply on hand moving into phase one as well as the ability to maintain their supply without relying on the state’s emergency stockpile. Further, the expectation is that providers develop and implement appropriate PPE use policies in accordance with the state and federal guidelines. **Second,** providers need to attest to meeting a set of public health and safety standards across several domains. The first domain is around workforce safety. This includes measures to ensure all workers have appropriate PPE, the facility or office must allow for proper social distancing, and protocol for screening all employers and employees entering the facility or office space. The second domain is around patient safety, which includes having policies and procedures in place for screening patients and symptoms, testing when medically appropriate, and requirements around face coverings. The third is around infection control measures including administrative and environmental controls that facilitate social distancing such as minimizing time in waiting areas, access to hand sanitizer, and established protocol for cleaning and disinfection. **Third,** providers and practices are required to designate a senior-level compliance officer who is responsible for ensuring adherence to the clinical and safety standards set forth in the guidance. Finally, as a matter process, providers are required to maintain an attestation form certifying that they meet all above criteria and requirements.

**Forum Presenter 2: Dr. Ben Kruskal**

Dr. Kruskal framed his presentation by discussing what the New England Quality Care Alliance (NEQCA) physician network is and talking about how that network has responded to COVID-19, and by speaking about precautions and PPE, staff help, and staffing models in the era of telehealth.

NEQCA is a partnership of academic and community physicians more than 1,500 spread across eastern Massachusetts, founded by Tufts Medical Center who is our academic medical center partner for advanced care. They are a bottom-up loose federation of about 200 independent practices with different EMRs, different staffing models, and distinct workflows. The central organization provides a number of supports and services to the practices, including contracting and payer relations, informatics, care management, clinical pharmacy, and a variety of other supports.

Dr. Kruskal notes that NEQCA’s response to the pandemic has not been unilateral. Some practices stopped seeing face-to-face visits completely as soon as the pandemic was noted. Others reduced face-to-face visits to a minimum of those absolutely necessary urgent visits. At NEQCA Central, the team rapidly created a website with extensive resources including clinical guidelines, educational materials, information on infection control, and supports for telehealth, coding, and billing. In addition, NEQCA Central started conducting weekly update webinars for both clinical and operational topics. They helped more than 120 practices start telehealth services in one week and have been supporting their practices in locating PPE. Most recently, they developed a comprehensive document of practice reactivation guidelines, which include sample policies to satisfy the DPH requirements.
Dr. Kruskal moved on to speaking about precautions and PPE. He noted that precautions are needed for droplet transmission. These include gloves, surgical masks and for any procedures that might involve splash or splatter, or for direct torso-to-torso contact which would be rare in the outpatient setting, much more common in the inpatient setting, a gown would be needed. In addition, for procedures that might involve a splash or splatter, eye protection is necessary, what's sometimes called enhanced droplet protection by adding the eye protection to the mask and gloves. Dr. Kruskal explained that there are two main categories of masks for this purpose. There are simple face masks, also called surgical masks or procedure masks and these are highly effective at preventing droplet spread. The other main category is what are called N95 masks, or N95 respirators. These are highly effective against the true airborne or droplet nucleus mode of transmission, however Dr. Kruskal noted that these are only really needed when aerosols are being generated by procedures which is quite common in the inpatient setting, especially in critical care, but very uncommon in the outpatient setting. In addition, he noted that it is important to know that N95 masks require fitting and fit testing to ensure a tight seal is achieved, and each time it is worn it needs to be tightly sealed, and therefore, users need some specific training. Dr. Kruskal continued and spoke to PPE, specifically where it can be acquired. He noted that the first place to start is with your regular suppliers, or distributors, or vendors. If they don't have PPE, look to others in the same category, or ask friends and colleagues. In addition, he notes that your practice’s affiliated hospital or health system may or may not be able to spare some PPE. Finally, he acknowledged that the Department of Public Health may be able to provide a small emergency supply for a few days, although it is important to understand that this is not a reliable source of PPE.

Next. Dr. Kruskal spoke briefly about provider and staff health. He noted that many health care organizations and practices are developing a process of all who work in the practice, daily, attesting that they have no symptoms which are suggestive of COVID 19. He emphasized that any staff member with symptom needs to be excluded until symptoms have abated including no fever and two negative PCR tests at least 24 hours apart. Alternatively, 10 days after the onset of symptoms, including three days afebrile with no antipyretics, and three days of resolved respiratory symptoms. In some cases, a strongly established alternative diagnosis may serve to allow staff to return to work, depending on clinical judgment by the provider. He notes that there is currently no recommendation to test asymptomatic staff or providers, except as part of a contact tracing program.

Finally, Dr. Kruskal touched on the role of support staff in the use of telehealth. He emphasized that having staff support makes a very big difference in the success of telehealth, the efficiency of telehealth, the smoothness and freedom from errors. Staff can make sure the patient's technology is working in advance of your trying to get on the interaction with the patient and can have the patient gather up all of their medications and any relevant devices, like glucometers and blood pressure cuffs. In addition, staff can ask all of the normal history questions that they would be asking in a face-to-face visit including things like the med list and allergies and review with the patient any preventive care that is due like mammography and colonoscopies. Finally, at the end of the visit, staff can schedule follow ups, referrals to specialists, and set up imaging.

**Forum Presenter 3: Dr. Michael Sheehy**

Dr. Sheehy began by giving a brief background of his organization, Reliant Medical Group. Reliant is located in central Massachusetts Metro West. Reliant has about 300 physicians and 200 advanced practitioners.
managing about 300,000 patients. They have 19 locations and are roughly split about half primary care and half specialists. They are an employed model and have four of their own urgent care centers.

Dr. Sheehy spoke about provider and patient schedules, emphasizing from the beginning that Reliant never truly shut down, because there were patients that still needed to be seen face-to-face. This past week, Reliant planned and expected about ¾ of providers and staff to return to their offices with about ¼ remaining to do remote care delivery via telehealth. This is an expectation that Reliant created over the last few weeks anticipating this reentry phase, really not knowing what kind of patient volume they’d expect. Dr. Sheehy noted that Reliant built their patient and provider schedule templates to be flexible so that any encounter on the template could be either a face-to-face visit or a video telehealth visit. In addition, they are asking that chronic or routine care be scheduled in the morning, same-day acute or sick visits scheduled in the afternoon to try to minimize any potential contact with COVID suspect patients. Reliant created and still maintains respiratory clinics. They strongly encourage patients to call to be triaged, and patients that are COVID suspect and that do need to be seen are triaged through our respiratory clinics. Finally, some specialties with a higher face-to-face requirement such as surgery, they targeted about half of the visits we expected would be face-to-face and about half via telehealth.

Dr. Sheehy moved on to speak about patient flow. He noted that universal screening and entry, universal masking and hand hygiene is expected of everyone who enters Reliant facilities. Reliant created signage and floor markings to remind the patients about social distancing when they're on site, and they have purchased and installed many sanitation stations throughout all sites and at the entrances and elevators, which are limited to four people with appropriate signage. Patients can also check in virtually, and they can pay their co-pays virtually. Reliant has trained medical assistants to escort patients promptly to exam rooms and in many instances if a patient virtually checks in, the medical assistant will go down to the entrance and meet the patient and escort them directly to the exam room. Medical Assistants also facilitate check out in exam rooms. Reliant the ability to draw labs in many of its facilities right in the exam room so the patients really can minimize any other time at other locations within the sites.

Next, Dr. Sheehy spoke about cleaning and disinfecting procedures at Reliant, and how they have created many new workflows around this issue. Reliant now has an expectation that all common areas, especially high touch common areas, will be wiped with the disinfectant a minimum of every four hours during working hours. This includes commonly touched areas like railings, doorknobs, elevator buttons, all common restrooms, and employee break rooms. Reliant also enhanced its cleaning and disinfecting standard work for exam room turnover. Reliant felt that with universal masking they really do not require a delay for air exchange in exam rooms, with exceptions that had been mentioned for any high aerosolization procedure. Reliant does require a two hour wait time for HVAC to change the air adequately for room turnover, in these instances. In the waiting areas, if patients do wait in any of the waiting areas, they're wiped down after every patient. In employee areas, Reliant has reduced staffing consistent with their provider and patient volume expectations and also to ensure social distancing. All employees do self-screen for symptoms and report to their manager on a daily basis as well as have a temporary screen at entry. In addition, Reliant staggered breaks and lunch and in break rooms they have restrictions around congregating and the number of employees, and also requirements on social distancing.
Finally, Dr. Sheehy spoke about patient risk stratification. He noted that risk stratification is what a majority of physicians have been wrestling with during the pandemic. He emphasized that there’s mounting evidence now that many people are not seeking needed medical care, or they're delaying until disease is far more progressive. Dr. Sheehy displayed and walked through the risk graph that Reliant created to attempt to strike a balance between recognizing COVID risk, and that is risk of morbidity and mortality for a patient if they were to acquire the COVID 19 virus. To view the graph, please click [here](#) (and move to the last slide of the full deck -- Dr. Sheehy’s deck). On the horizontal graph, rising risk goes higher left to right, and on the vertical axis is increasing clinical condition risk with examples given. He also noted that based on state, national and international data one of the biggest risk factors of COVID morbidity and mortality is age. Based on this fact, Reliant created a simple COVID risk score calculator which uses increasing age with a score of 0 to 3, and sums it with a number of known comorbidities, again 0 through 3. It is meant to be used as a simplified grid to help give some conceptual guidance to our physicians, our advanced practitioners, and our triage nurses to help guide decisions in site of service. Lastly, Dr. Sheehy noted that each and every one of these decisions should be made by the clinician on a one by one basis. He emphasized that clinicians really have to make these decisions one by one. If they feel as a clinician that the benefits of bringing the patient into the office outweigh the risks, then that's how they should decide.

Responses to questions received from members during the MMS Virtual Member Forum

- **Dr. Spivak**: New guidance from the DPH was released on May 25th, 2020 regarding the attestation form. Could someone please summarize this guidance?

  **Torey McNama**: All providers that are not part of hospitals need to complete the attestation form. There is a slightly updated form available online, and it has been updated to reflect that this form must be maintained onsite, but does not need to be submitted to the state. Other updates include clarification that one attestation only can be maintained for a practice or a group of practices across multiple sites, so long as the person that is indicated on the attestation form as the compliance leader is able to assure compliance across all of the sites and all of the providers across the sites. We hope this is helpful so that each site is not having to complete the attestation process independently. It is also important to maintain one copy of the attestation at each site so it is readily available, if need be.

- **Dr. Spivak**: One of the concerns many providers have raised is that there are many offices that have continued to stay open over the last ten weeks, do they need to attest?

  **Torey McNama**: We obviously understand that providers have continued to provide care. We hope that they have tried to keep that constrained to the most emergent of situations, but understand and recognize that care has been provided. We do want to reinforce the importance of the public health and safety standards required for phase one, while also acknowledging some of that care has occurred. Any providers that are doing non-emergency services in person should work to meet the attestation standards as soon as possible and then maintain a copy of that so that's available.

- **Dr. Spivak**: Do Psychiatrists who clearly have no physical contact with patients at all need to attest?

  **Torey McNama**: Yes, psychiatrists are subject to the attestation requirements and all of the other public health and safety standards and protocols. I would like to also make a plug here for
the continued use of telehealth when possible. We’ve seen a successful uptake in utilization for behavioral health services provided through telehealth modalities, so I would urge membership to continue pursuing that.

- **Dr. Spivak**: Dr. Sheehy, as you’re reforming your offices how are you changing staffing patterns? Are you using medical assistants to clean the rooms? How are you dealing with staffing issues in smaller offices?

  **Dr. Sheehy**: Medical Assistants have always done at least disinfecting of exam room turnover, but typically do not clean common space areas. We vend out to a housekeeping cleaning company for cleaning of the common areas and restrooms. Previously, the housekeeping company only completed those tasks once in a 24-hour cycle, but we have had to increase that significantly. We have had to add FTE’s (full time employees) and have had to redeploy some of our own staff to help clean some of the waiting areas whenever they see something that needs to be wiped. Everyone is responsible for keeping their own clinical space disinfected based on our own internal guidelines. So, it’s a mix of both vended housekeeping, which we have increased, and our own staff redeploying.

- **Dr. Spivak**: Dr. Kruskal, there have been several questions about masking. How often do you have to change surgical masks, and can you clean them? Do N95 masks really need to be fitted? What constitutes an aerosolized procedure, and does doing a nasopharyngeal swab constitute an aerosolized procedure?

  **Dr. Kruskal**: No kinds of swabs generate aerosols. Nasopharyngeal swabs are perfectly safe to do with a surgical mask. In terms of duration for surgical mask use, the strict guideline is that these masks can be used until they are wet, soiled or torn. I would certainly not use a surgical mask for more than eight hours. One of the things to remember is that while extended use is fine, but taking the mask off and putting it back on poses substantial risk. The outer surface of a surgical mask gets contaminated by virtue of filtering out respiratory droplets and if you touch that surface when you’re taking a mask off or putting it back on again, you contaminate your hands. So, reuse of masks is not recommended. In the case of N95s with the severe shortage the hospitals have had, they have developed reprocessing techniques to sterilize the masks after use. N95 masks do need to be fitted. They need to be fitted and tested, and you need to be trained in using them and trained in how to check the fit when you put the mask on each time. It’s not trivial, it’s really important. Otherwise, you’re just using the 95 as a very expensive surgical mask. I would also like to reiterate that you really don’t need an N95 in the ambulatory office setting, unless you’re doing aerosol generating procedures, which you just don’t do any in the ambulatory setting with the exception nebulizer treatment, which as I said we should choose not to do because of the risk.

- **Dr. Spivak**: Many hospitals have methods for recycling and disinfecting masks, however most ambulatory offices do not have access to that. Is there any thought about requiring offices to work with their ambulatory offices to provide sterilization and decontamination of masks?
Lauren Peters: At a high level, I would encourage practices to work with their broader hospital or provider systems to help ensure sourcing PPE and other resources around PPE to the extent possible.

Kate Fillo: Collaborating with hospitals and larger partners in order to have a sustainable model for access to PPE is critical. Here in Massachusetts, we do have a health system that has a BATTELLE CCDS Critical Care Decontamination System for PPE Decontamination and have made that available to entities outside of the organization. We also have a process for being able to access that and it has worked well thus far. In addition, the FDA has done some emergency use authorizations for common decontamination machines to be used to potentially reprocess respirators, as well. So, that can be an option in terms of partnering with an entity who has access to one of those machines.

- **Dr. Spivak:** If providers are being asked to continue to use and maximize telemedicine and video visits, will payment remain at parity with office visits as they are now, so that they can afford to do that?

  Lauren Peters: The telehealth issue has been around, and it comes up every legislative session. It is something that the governor filed in his bill back in the fall, so this is something we are interested in pursuing beyond the state of emergency. For the near term, we are pursuing a way to ensure that those policies remain in place after the state of emergency is lifted. Now, whether the policy is exactly the same as it is now, which is payment parity may change and we may move to coverage parity, which is what was proposed in the governor’s bill in the fall. In either scenario, we are interested and intend to pursue the extension of this policy around commercial and MassHealth coverage of telehealth services, even beyond the state of emergency.

- **Dr. Spivak:** How are you going to make your patients feel safe enough to want to come into the office? What is the message that you are going to send out to your patients?

  Dr. Sheehy: This is a question that we all need to be really concerned about because it is fear that keeps them away. We have a communication strategy that is multipronged. We have direct email and we've already sent out a letter outlining and bulleted some of the very specific steps that we've put in place to do our best to ensure patient safety. This is going to be something that's just ongoing. It's not something that you can just communicate once, but it has to be reinforced over and over again. As time goes on, I think we are going to come to find that the risk of acquiring COVID 19 infection in physician offices, provided that we have all the appropriate steps in place the risk, is exceedingly low.

  Dr. Kruskal: It is essential to not only do it right but also to communicate it effectively to patients. We have to become infection control experts, because we need to have the confidence and exude that confidence. We need to have our staff be able to have that confidence to be able to answer questions clearly and confidently in order for patients to feel safe.

- **Dr. Spivak:** Dr. Schwarz, could you speak to the role that the State is going to play in ensuring patients of the safety of the healthcare system?
**Dr. Schwarz:** The state has a large role in communicating this. I would say we’re playing two roles. One, I think it’s fair to say that patients are most comfortable hearing not from the government, but from a provider that they trust. So part of our role actually is to support the right organizations with what they need in order to make patients feel safe and to hopefully support all providers directly to help communicate these messages to the patients that they know and trust you, not the kind of amorphous government. On the other hand, the State has a marketing campaign that's already started. It started during the pandemic, and as we anticipate phase two, there's plans in development for another set of marketing messages that will be coming out. And one of the challenges I think that we have moving forward is specifically around testing and comfort with the healthcare setting. In addition, now that there is testing capacity, the messaging needs to change within the community to more broadly encourage people to get tested.

**Dr. Spivak:** What is the role of testing for your providers, staff and patients as you bring them in to ambulatory offices? What are you advising your practices to do?

**Dr. Kruskal:** For both staff and patients, there is no recommendation to test when asymptomatic except in the context of contact tracing. Symptom screening, fever screening or staff symptom screening is certainly worth doing. In terms of patients, I think you may want to take a temperature of a patient when they're in the office, but I wouldn't turn them around and send them home if they have a fever. You're there to evaluate them and decide what needs happen with them.

**Dr. Sheehy:** At Reliant, we generally follow the same guidelines Dr. Kruskal spoke to. I do want to mention that we've wrestled with this question about whether or not to test all of our providers, at least all of our providers that are in high risk clinical situations, including our pulmonologists, hospitalists and infectious disease specialists. We've debated this topic for many hours on our executive team, and I think at this point we have no plans to test unless symptomatic.

**Dr. Fillo:** We recommend and are working very hard to expand our testing capacity here in the State through both labs that are able to process testing as well as innovative options and partners to be able to bring testing into the communities and into congregate care settings as well as into practices. We have expanded our Department of Public Health recommendations for testing to anyone who is confirmed as having close contact with a case of COVID-19. Working on testing is one of the tenants of the way that we are going to be able to address COVID 19, as well as with isolation and, as appropriate, with confirmed cases and social distancing. So really putting a lot of energy into being able to have expansive testing is a top priority.
• Dr. Spivak: Do you have to retest a COVID positive patient to make sure they are negative before letting them back in to the community? More importantly, if you must bring the patient back in to the office, do you want them to be tested and COVID negative before bringing them back?

Dr. Kruskal: We do not generally use negative testing as a criterion to let people come back into the community. The reason is that the PCR test, the test for active infection, can detect fragment of virus, viral RNA to be specific, for long after there is no viable organism and no infectious virus present. You can test positive for many weeks after the infection has been successfully eradicated.

Dr. Sheehy: Reliant’s position is similar to NECQA. With universal masking, this should not be an issue. Clearly, there are asymptomatic carriers and then there are false positives of several weeks after an acute illness. Again, with universal precautions, the risk of transmission should be quite low.

• Dr. Spivak: Ambulatory offices are very different than the hospitals in terms of their moving from phase one to phase two to phase three. It’s easy to look at the hospital and see what their bed capacity, ventilator capacity, and ICU capacity is. How are you going to decide that an ambulatory pediatric primary care, OB, or specialty office is ready to move from phase one to phase two or three?

Lauren Peters: This is something the State is actively discussing and thinking about. As phase 1 begins, we are hoping to work with stakeholder groups, such as the Massachusetts Medical Society, and bring them to the table to think about relevant indicators or metrics we should be monitoring throughout the course of phase 1. These include looking at PPE impact, the level of transfer to hospitalizations and other considerations that have a direct impact on the overall health care system’s ability to maintain capacity for COVID treatment. The hospital capacity metrics that we set both at the statewide level and individual level are threshold metrics we felt needed to be in place and needed to be met in order to start phase 1. Now, as we start thinking about future phases, we’re hoping to track additional metrics and indicators that will signal to us whether the system has the capacity to take on or resume additional services. This will be weighed against ensuring that there’s access to some of the important critical services for patients that are in need of medical treatment. Certainly, it’s a balancing act. We hope that we can solicit feedback from organizations to understand what some of these important metrics and indicators that we should be looking for are as we think about strategies for phase 2.

• Dr. Spivak: What are the consequences, if any, for ambulatory practices who do not follow the phases that either don’t attest or don’t have the perfect amount of PPE they need? Will there be consequences for practices that move in to phase two, three or normality before the state has set its time?

Lauren Peters: The state maintains the authority to monitor compliance and can require remedial action as warranted. So, we do maintain that level of discretion.

Torey McNamara: There is certainly, as Lauren noted, the ability to take action if necessary. However, I think the important thing is that the State has put these criteria, and the attestation process, in place to try and drive home that we’re seriously and cautiously approaching
reopening and trying to put some guardrails in place. Additionally, it is to impress the importance of these steps of the process to ensure patients and healthcare workers are safe, but it is not meant to be a punitive process. It’s really just trying to put forward a framework that we can get up and running as we continue to follow certain metrics.

- **Dr. Spivak:** What do you suggest a small office practice does if they cannot get the best and required PPE that they need? Do you suggest they close, stop seeing, patients, or attempt to create makeshift equipment? What are your recommendations?

  **Lauren Peters:** We would say if there is a procedure or service scheduled and the staff do not have the appropriate PPE onsite on-hand for that service, our guidance is the service or procedure needs to be canceled. More generally, PPE has been a challenge throughout the course of this pandemic. As we think about reopening, the reopening team is working with the medical emergency response team to produce a list of PPE suppliers to make available to providers and business groups who assist with PPE purchasing. That list will be a resource for those that are having trouble identifying a supply chain or sourcing to ensure that they have adequate supply. The state does have an emergency stockpile of PPE. We view that truly for emergent situations as a bridge if there is an instance where, say, you have an order for PPE and it doesn't come in on time. That PPE is available in very, very limited circumstances. For a provider to be able to enter phase 1 and demonstrate that they have an adequate PPE supply, they cannot rely on the state's emergency stockpile. So, we do expect that providers, if they are moving into phase one and starting to expand the services that they are resuming, have an adequate PPE supply that they're able to maintain. We have comprehensive PPE guidance that we have put out as a state, and we do continue to update that on a regular basis.

- **Dr. Spivak:** Many ambulatory providers have been financially hurt in this crisis and are not doing the same number of telemedicine health visits that they were doing as in-person visits. Is there any thought by the State as to how they are going to help ambulatory practices get through this? Is there any thought from the state of helping the providers on the ambulatory side to get through this financially?

  **Amanda Cassel Kraft:** We certainly appreciate the challenges many health care providers and many businesses are experiencing during this period. We have taken some steps and are continuing to think about this even while the state is quite challenged thinking about the economic future. On the MassHealth side, we have increased provider rates for physicians and group practices 15% over four months from April through July, which as folks start to increase the volume of services, should be a help and a support. Part of that is really intended to encourage practices to do as much as they can using telehealth. We do pay an equal rate for telehealth services as we would pay for in-person service and during this period, commercial plans in the state are also doing the same. We are also in dialogue with our federal partners. There's quite a bit of the provider relief funding from the CARES Act that hasn’t been distributed or allocated yet, and we have encouraged our federal partners to think about those providers who haven't yet received significant federal relief, particularly those who are safety net providers and serving the Medicaid population. Additionally, we are in the process of working through some additional steps that we might be able to take. I think it's too early for us to share any details of that, and I don't want to overpromise anything, but
we're taking a look at high volume Medicaid physician practices and those that serve a large number of our members to see if we can provide some short-term support that would be helpful to those practices. Finally, we've started discussions with care members and others about how we, as a commonwealth can really on a multi payer basis, think about primary care differently. So, we're certainly very sensitive to the challenges that folks have. While we're limited in the resources that we have available, we're trying to think through different options and also continue to work with our federal partners.

- **Dr. Spivak:** Before I close, are there any closing comments by any of the panelists?

  **Lauren Peters:** As we start to think about the future, we want to hear from you all and what are the services that you're seeing that there is a pent-up demand for. In addition, how are you prioritizing services? I think one thing that's important to us is in maintaining health access across all communities regardless of what region of the state they're in. We want to ensure that there's equitable access for these critical, high-priority preventative care services, particularly pediatric services. We really look forward to hearing from you all about what you're seeing over the next couple of weeks in terms of what are the services you're seeing folks coming in for. Are there services that you're not seeing patients coming in for and are you still seeing a level of fear out there that is sort of limiting or inhibiting patients from coming in and seeking treatment? We are relying on the feedback that you provide for us about what you are seeing on the ground to help inform the way that we think about future phases, and it's really important. We really appreciate your engagement on this issue.

On behalf of all the leadership of the MMS, Dr Bombaugh thanked the speakers for sharing their insights and perspectives and the members for their questions and participation in the forum.

**Resources and Information**

To view the slide deck containing the slides from each of the presentations below, please click [here](#).