Member Forum: Preparing Practice Operations and Delivering Patient Care During COVID-19
Slide Deck
May 26th, 2020
Health and Human Services (HHS) Reopening Approach

- Many health care services (hospitals, nursing facilities, home care, residential care within human services) have continued throughout the pandemic. Emergency services have been ongoing. Use of telehealth has expanded rapidly to meet many health care needs remotely.

- Recent, encouraging trends show that the impact on the state’s health care system is beginning to abate.

- Goals for Phase 1 (Start): 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 COVID-19 treatment.

- Approach to Phase 1 reopening for health care:
  - Initiating Phase 1 is contingent on sufficient statewide hospital capacity being available (≥30% for staffed adult ICU beds and total adult inpatient beds¹), which currently has been met and must be maintained through 5/25.
  - Effective May 18, hospitals and Community Health Centers who attest to meeting specific capacity criteria and public health/safety standards will be allowed to resume a limited set of services in-person.
  - Effective May 25, other health care providers who attest to meeting these standards may resume limited services in-person.
  - In-person services are limited to the following, based on the provider’s clinical judgment:
    - (1) high-priority preventative care such as pediatric care and chronic disease care for high-risk patients; and
    - (2) 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.
  - Telehealth should continue whenever appropriate, and emergency and in-home services should continue.

¹ Metrics for ICU and total inpatient beds include hospital surge capacity.
Phased reopening will begin with limited set of services for a subset of providers that meet public health/safety standards

**HHS Reopening Approach**

**Phase 1: Start**
- Continue to maintain close monitoring and oversight of hospitals, nursing facilities, group homes, etc.

**Phase 2 and 3: Cautious and Vigilant**
- Evaluate when certain restrictions can be modified

**Phase 4: New Normal**
- All services may reopen with guidelines in place

### Services Currently Operating
- Open with restrictions, focus on emergency and COVID treatment

### Delayed/Deferred Services
- Elective in-person services closed with exceptions for emergencies
  - **5/18 or 5/25**: Providers who attest to meeting public health standards can provide a limited set of services:
    - High-priority preventative services such as pediatric care and chronic disease care for high-risk patients
    - Urgent procedures/services that cannot be delivered remotely, would lead to high risk or significant worsening of the patient’s condition if deferred

### Services Delivered Remotely/via Tele
- Telehealth / remote delivery increased significantly during emergency
  - Maximize telehealth to the greatest extent possible, including pre-appointment screenings
  - Encourage primary care and others to expand telehealth and remote care delivery
  - Preventative care, wellness, and chronic disease management managed through telehealth/remote monitoring as much as possible

*Hospitals and community health centers that meet and attest to all bed capacity and public health/safety standards may begin starting 5/18; others starting 5/25*
Phase 1 reopening is contingent on sufficient statewide hospital capacity being maintained

<table>
<thead>
<tr>
<th>Metric</th>
<th>Statewide threshold that must be met</th>
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<tbody>
<tr>
<td>Staffed adult ICU capacity (including staffed surge capacity)</td>
<td>≥30% available</td>
</tr>
<tr>
<td>Staffed total adult bed capacity (including staffed surge capacity)</td>
<td>≥30% available</td>
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</tbody>
</table>

These metrics are currently met and must be maintained through at least 5/25 in order to move forward with Phase 1 for health care providers (hospitals and non hospital providers)

Note: in order for an individual hospital or hospital system to proceed into Phase 1, that hospital or health system must must also have ≥25% available capacity (≥25% staffed adult ICU and ≥25% total adult bed capacity, including staffed surge capacity). Whether an individual hospital or health system meets the available capacity required does not affect the ability of other providers to proceed
Summary: Criteria for Non-Hospital Providers to Begin Phase 1 Services

1. Sufficient Statewide Capacity
   - Statewide Acute Care Hospital Available Staffed Adult ICU Bed Capacity ≥30% AND
   - Statewide Acute Care Hospital Available Staffed Adult Total Bed Capacity ≥30%
   - The state must have sufficient hospital capacity before non-hospital providers begin other services

2. Provider Attestation
   - PPE
     - Non-hospital providers must attest to: 1) having an adequate supply of PPE on hand prior to Phase 1; 2.) the ability to maintain adequate PPE supply on an ongoing basis without requiring distribution of PPE from government emergency stockpiles
   - Public Health/Safety Standards
     - Non-hospital providers must attest to meeting certain public health and safety standards in the following domains: 1.) Workforce Safety; 2.) Patient Safety; and 3.) Infection Control
   - Governance
     - Non-hospital providers must designate a compliance leader at the highest level of the organization to ensure compliance with the clinical and safety standards.
   - Attestation/Compliance Process
     - Non-hospital providers must maintain an attestation form* certifying that they meet clinical, capacity, safety standards, and governance requirements. The state maintains the authority to monitor compliance and require remedial action as warranted.

* Community health centers that attest to meeting all requirements and plan to begin Phase 1 services before May 25 must notify and submit their signed attestation to DPH
Summary: Criteria for an Acute Care Hospital to Begin Phase 1 Services

1. Sufficient Statewide Capacity
   - Statewide Acute Care Hospital Available Staffed Adult ICU Bed Capacity ≥30%
   - AND
   - Statewide Acute Care Hospital Available Staffed Adult Total Bed Capacity ≥30%

2. Individual Hospital or Hospital System Attestation
   - Hospital/Hospital System Initial Capacity
     - Hospitals or hospital systems must attest to ≥25% available staffed adult ICU beds capacity AND ≥25% available staffed adult med/surg bed capacity
   - Hospital/Hospital System Ongoing Capacity
     - Hospitals or hospital systems must commit to maintaining ≥20% available staffed adult ICU and med/surg bed capacity throughout Phase 1 (including surge)
   - Restore Essential Capacity and Staffing
     - Hospitals must attest to 1.) reopening any temporarily closed or reduced capacity in pediatric ICU units and inpatient psychiatric/behavioral health units; and 2.) reinstating mandated ICU staffing ratios
   - PPE Supply
     - Hospitals must attest to: 1) having a 14-day supply of PPE on hand prior to Phase 1; and 2.) the ability to maintain adequate PPE supply on an ongoing basis without requiring distribution of PPE from government emergency stockpiles
   - Public Health/Safety Standards
     - Hospitals must attest to meeting certain public health and safety standards in the following domains: 1.) Workforce Safety; 2.) Patient Safety; and 3.) Infection Control
   - Governance
     - Hospitals must attest to maintaining an internal governance structure at the highest level of the organization to ensure compliance with the clinical, capacity, and safety standards. Governance body must include health care labor representation.
   - Attestation/Compliance Process
     - Hospitals must submit an attestation form to the state certifying that they meet clinical, capacity, safety standards, and governance requirements. The state maintains the authority to monitor compliance and require remedial action as warranted.

Notes:
1. Hospital bed capacity measures include surge beds where they exist.
2. Hospital systems are required to assess their total bed capacity at the system level.
3. Dana Farber Cancer Institute and Boston Children's Hospital are excluded from these requirements.
Phase 1: Approach for pediatrics

• Because of unique considerations for children, during Phase 1, routine pediatric care should resume, including in-person well child visits
  - Pediatric primary care is essential to identify and address medical, developmental, behavioral and social needs
  - During the COVID-19 emergency there has been a precipitous drop in scheduled vaccines (~60% decline) and reporting of possible child abuse and neglect (~50% decline in 51A reports), creating significant risks to children

• As a result, Phase 1 guidelines for pediatric care include:
  - Catching up on missed scheduled vaccines should be prioritized
  - Well child visits may occur in-person; providers should determine if in-person or telehealth visit is clinically appropriate, based on factors such as age, need for vaccination, or concern for developmental or social risk
  - As always and particularly during the COVID-19 emergency, providers should be sure to screen for social needs, behavioral health, child abuse, and intimate partner violence
  - For sick visits, providers should continue to determine whether in-person or telehealth is clinically appropriate

• Public health precautions remain critical
  - Prior to resuming routine in-person visits, all providers must first attest to meeting all DPH standards (e.g., PPE, workforce and patient screening for COVID-19, social distancing, cleaning, etc.)
  - Contact between patients should be minimized through scheduling (different times of day or separate space in clinic for well child visits vs. sick visits to avoid possible exposure)
# Examples of in-person services that should start in Phase 1

<table>
<thead>
<tr>
<th>Types of in-person services</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>• High priority preventative visits that lead to high risk if</td>
<td>• Pediatric visits, screenings for at risk patients (colonoscopies for individuals with family history of cancer), chronic disease management visits for high risk patients, placement of implantable contraception</td>
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<tr>
<td>deferred</td>
<td></td>
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<tr>
<td>• Diagnostic procedures where delay would lead to high risk</td>
<td>• Mammograms for women with prior concerning findings, colonoscopy for blood in stool, biopsy for concerning lesions/potential cancers, urgent labs, blood draws</td>
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<tr>
<td>• Physical exams for new concerning symptoms</td>
<td>• In-person examination for breast lump, post-menopausal vaginal bleeding, chest pain, blurred vision, or other concerning symptoms</td>
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<tr>
<td>• Medical procedures that if deferred lead to substantial</td>
<td>• Removal of malignant skin lesions, orthopedic procedures to treat significant functional impairment or condition at risk of significantly worsening</td>
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<tr>
<td>worsening of disease</td>
<td></td>
</tr>
<tr>
<td>• In-person visits for high risk behavioral health and/or social</td>
<td>• Substance use disorder treatment including Medication Assisted Treatment</td>
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<tr>
<td>factors</td>
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<tr>
<td>• Dental procedures that are high risk if deferred</td>
<td>• Tooth extractions for significant infections</td>
</tr>
<tr>
<td>• Rehabilitation where delay would lead to significant worsening</td>
<td>• Rehabilitation for post-stroke patients or severe traumatic injuries, post-operative physical therapy</td>
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<tr>
<td>of condition and long-term prognosis</td>
<td></td>
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</table>

The health care provider will use their clinical judgment to determine which services meet the criteria outlined for in-person services.
### Examples of in-person services that should not start in person in Phase 1

<table>
<thead>
<tr>
<th>Types of services</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative visits that do not lead to high risk or significant worsening if deferred</td>
<td>Routine annual exams for adults, screenings (e.g., 10-year colonoscopy, 2-year mammogram), routine eye exam, dermatology exams for low-risk patients</td>
</tr>
<tr>
<td>Diagnostic procedures that do not lead to high risk or significant worsening if deferred</td>
<td>Blood draws for routine monitoring of chronic disease</td>
</tr>
<tr>
<td>Medical procedures that do not lead to high risk or significant worsening if deferred</td>
<td>All cosmetic surgeries, bariatric surgery, other elective procedures including most elective joint replacement or back surgeries, ear tube placements, tonsillectomies, cataract procedures for individuals not at high risk</td>
</tr>
<tr>
<td>Behavioral health care that is low risk or group</td>
<td>Day programs and in-person group therapy and visits, routine consultations or consultations that can otherwise be done via telehealth</td>
</tr>
<tr>
<td>Dental procedures that do not lead to high risk or significant worsening if deferred</td>
<td>Routine dental cleanings</td>
</tr>
<tr>
<td>Rehabilitation services that do not lead to high risk or significant worsening if deferred</td>
<td>Most physical therapy and chiropractic care</td>
</tr>
</tbody>
</table>

In certain cases, these services may be provided in-person in Phase 1 if a health care provider makes a clinical determination based on the patient’s condition that delay would lead to high risk or significant worsening of the patient’s condition.

**IN THE CASE OF AN EMERGENCY, INDIVIDUALS SHOULD SEEK IMMEDIATE MEDICAL ATTENTION**
Preparing Practice Operations & Delivering Patient Care During COVID-19: The View from NEQCA

Ben Kruskal, MD
Medical Director
Agenda

Context: What is NEQCA?
How NEQCA has dealt with Covid-19
PPE
Staff health
Staffing models in the telehealth era
Academic/community partnership of >1500 physicians across eastern Mass., founded by Tufts Medical Center, our AMC partner for advanced care.

Secondary care is kept local, utilizing community hospitals close to the patient’s home.

Bottom-up loose federation of ~200 practices with different EMRs, different staffing models, distinct workflows.

NEQCA Central provides contracting & payer relations, informatics, care management, clinical pharmacy, and coding support to the network practices.

What is NEQCA?
Some practices stopped seeing face to face visits completely; some reduced face to face visits to a minimum of absolutely necessary visits

NEQCA Central

• Created a website with extensive resources: educational materials, clinical guidelines, infection control information, telehealth coding
• Weekly clinical/operational update webinars
• Started telehealth services for ~120 practices in 1 week
• Supported practices in locating PPE
  • Developed comprehensive Practice Reactivation Guidelines (including sample policies to satisfy the DPH Phase 1 Reopening Guidelines)
TRANSMISSION-BASED PRECAUTIONS

- Diarrhea
- TB

AIRBORNE PRECAUTIONS

- Measles
- Varicella

DROPLET PRECAUTIONS

- Influenza
- Mumps
- Pertussis

STANDARD PRECAUTIONS

- HIV and other blood borne
- All pts treated as if might transmit

UNIVERSAL DROPLET PRECAUTIONS

- Covid-19
- All pts treated as if might transmit
Droplet precautions

Surgical mask

Gloves

Gown only needed for splash/splatter/direct torso-to-torso contact

Eye protection:  “Enhanced droplet protection” for splash/splatter
Medical Masks

Simple facemask (Surgical mask, procedure mask)
- Highly effective against droplet spread

Only needed for aerosol generating procedures
- Highly effective against airborne (droplet nuclei) spread
- Requires one-time fitting/fit-testing/training
Where to get PPE

Your regular supplier/distributor/vendor

Another typical commercial supplier/distributor/vendor
  • Ask your friends

Ask your affiliated hospital or health system

DPH may be able to provide a few days’ emergency supply but may not be counted upon in complying with the reactivation guidelines
All should daily attest that they have no symptoms suggestive of Covid-19 (Fever, chills, cough, shortness of breath or difficulty breathing, sore throat, muscle aches, vomiting or diarrhea, new loss of taste or smell)

• Anyone with symptoms should be excluded until:
  - 2 negative PCR tests for COVID-19 at least 24 hours apart, afebrile and improved respiratory symptoms OR
  - 10 d after symptom onset with 3 days afebrile/no antipyretics and 3 days resolved respiratory symptoms OR
  - POSSIBLY strong alternative diagnosis established

Currently no recommendation to test asymptomatic staff except as part of a contact tracing program
Staff roles in Telehealth

• Make sure patient technology is working
• Have patient gather all meds and devices
• Normal history questions including med list and allergies
• Review preventive care that’s due
• VS as possible and appropriate (home BP machine, temp, weight, respirations by inspection)
• Schedule follow ups, refer to specialists, imaging
Practice Operations and Patient Care During COVID 19

Dr. Michael Sheehy
Reliant Medical Group
Chief of Population Health & Analytics
Reliant Medical Group

299 Physicians

197 Advanced Practitioners

2500 Employees

317,000 Patients

19 Clinical Locations

- Adult Medicine
- Pediatrics
- Geriatrics
- Specialty Care
- Urgent Care
- Occupational Health
- Durable Medical Equipment
- Optical Care
- The Endoscopy Center
- Laboratory
- Radiology
- Rehabilitation and Sports Medicine

(May 2019)
Clinical Operations Expansion - Environmental Management
Environmental Management – Provider/patient schedules

75% of providers and staff to return to offices, 25% remain remote to deliver care via telehealth/video

Expect 25% on-site encounters to be face to face (F2F), 75% telehealth/video

Templates built to flex: any encounter can be F2F or telehealth/video

Chronic/routine care in AM, acute care in PM

Some specialties with higher F2F requirements will target 50% F2F and 50% telehealth/video
Environmental Management – Patient Flow

Screening at entry, universal masking and hand hygiene
Signage and floor markings for social distancing
Sanitation stations throughout the sites and at elevators (limit 4 people)
Patients can check-in and pay co-pay virtually to reduce time in our sites
MA escorts patients promptly to exam rooms and facilitates check-out in exam rooms
Environment Management – Cleaning and Disinfecting

Disinfect common areas minimum of every 4 hours with date/time stamp

- Railings, door knobs, elevators
- Common area rest rooms
- Employee break rooms

Enhanced cleaning during exam room turnover

- Use of Caviwipes, one new wipe per item/surface
- All touch surfaces i.e. door knobs, faucet handles, BP cuff, etc.
- With universal masking a delay for air exchange not needed; exceptions for high aerosolization procedures = 2 hr room turnover

Waiting area surfaces wiped after every patient
Reduce staffing consistent with provider/patient volume, and to ensure social distancing

All employees self-screen for symptoms and report to manager, as well as temp screen at entry

Stagger breaks and lunch

Breakroom restrictions around congregating, number of employees and social distancing
Patient Risk Stratification

Determining site of service: Balancing the risk of COVID-19 morbidity and mortality with the risk of the clinical condition to treat

Mounting evidence that many people are not seeking needed medical care, or are delaying until disease progression

5/19/20 NEJM: Kaiser Northern CA data showed weekly hosp rates for acute MI dropped by as much as 48% compared to same weekly data 2019
Higher Clinical condition risk

Example: Otherwise healthy 32 y/o with acute abd pain or acute injuries
Conduct F2F visit

Example: Elderly frail diabetic with CHF and SOB
Benefit of F2F outweighs risks

Lower Clinical condition risk

Example: 41 y/o male typical GERD symptoms
Virtual visits if possible

Example: 76 y/o with new knee pain
Virtual visit – COVID risk may outweigh benefit of F2F
Clinical benefit scoring examples

High:
- HF/COPD exacerbation
- Syncope with fall
- Acute mental status change
- New onset CP or SOB
- Bite wound
- Diabetic foot ulcer
- Well visits for newborns and young children not current on immunizations

Medium:
- Acute MSK pain with trauma
- Headache
- EGD (h/o varices)
- Immunizations (pneumococcal, influenza)

Low:
- UTI
- Screening colonoscopy or EGD
- Acute/chronic MSK pain with no red flags
- Epidural steroid injections
- DEXA scans
- Physical therapy

Qualifying comorbidities for COVID risk:
- Chronic lung disease (COPD, pulmonary fibrosis, CF, moderate persistent asthma)
- Serious heart disease (HF, aortic stenosis, congenital, pulmonary hypertension, severe uncontrolled hypertension
- Active malignancy with ongoing treatment
- Immunocompromised state or immunosuppressive medications
- Severe obesity (BMI 40 or higher)
- Diabetes requiring medications
- Dialysis – dependent
- Advanced liver disease

COVID risk score calculator

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;50</th>
<th>50-64</th>
<th>65-79</th>
<th>80+</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>3+</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Risk benefit decision support matrix for patient scheduling and place of service

For COVID risk scores:
- High (6+): F2F preferred
- Medium (2-5): It depends
- Low (0-1): Virtual preferred

Consider deferral if score is 5 or below.