Medical Practice Reactivation Guide

Navigating what's next in a COVID-19 era

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NEQCA

New England Quality Care Alliance

Affiliated with Tufts Medical Center

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Introduction

In just two months, our world has changed. As a colleague recently observed, "We all look the same, but now see each other differently. There is no unlearning the fact that each of us is a link in a social chain that potentially threatens the life of another."

From COVID-19's earliest onset, NEQCA leadership made it a priority to support our Network and to safeguard our Braintree headquarters colleagues. We remain focused on the following priorities, even as we plan for the longer-term impacts of COVID-19 on our Network:

- **Clinical support –** We continue to monitor, aggregate and disseminate COVID-19 clinical guidance to our Network under the medical direction of Dr. Ben Kruskal, our talented and experienced infectious disease specialist. Information is shared through regular, direct outreach to our LCOs and practices, through our well-attended COVID-19 educational webinar series, and via a robust website with a wealth of information for providers and patients.

- **Operational support –** We have redeployed numerous NEQCA Central colleagues to meet emerging Network needs. One team now supports telehealth services across many platforms (e.g., Amwell, Doxy.me, Zoom), as well as providing coding and billing guidance. Our Care Management and Pharmacy teams have pivoted from traditional responsibilities to support our practices in the care of confirmed or presumptive COVID-19 patients. We also have partnered with our LCO leadership to assess every practice in our Network to determine its "health status" based on estimated practice in-person and telehealth volume, as well as staffing, use of telehealth, adequacy of PPE. Findings are being used to prioritize how and where NEQCA Central should direct its programs and services.

- **Economic sustainability –** COVID-19's impact on the financial wellbeing of our private practices has clearly been substantial. As reimbursements for non-urgent patient visits started to decline, NEQCA processed and distributed two interim contract efficiency settlements to our LCOs (March and May) to provide revenue to sustain practice operations. NEQCA Management also remains actively engaged in the Wellforce Private Practice Sustainability Work Group. This work group has developed a "Private Practice Recession Survival Guide," which is regularly updated with actionable information about loans, advances and grants. Drop-in Q&A Sessions are hosted weekly to help our practices find solutions to the economic challenges they face.

- **Emotional wellbeing**. The COVID-19 pandemic is taking a toll on everyone, especially caregivers. NEQCA's newly chartered Clinician Wellbeing and Satisfaction Council, under the direction of Drs. Andrew Chandler and Jatin Dave, hosted a clinician wellbeing webinar and launched a new section of NEQCA's website – "The Fourth Aim: Higher Clinician Satisfaction"– with links to numerous wellbeing resources such as videos produced by our colleagues at Tufts Medical Center.

Introduction (continued)

NEQCA is now focused on supporting our Network through a prolonged period of COVID-19 recovery and expected recurrences by helping our practices:

- Secure reliable access to PPE and COVID-19 testing
- Redesign office workflows and protocols to limit COVID-19 exposure such as prescreening guidelines, worksite adaptations to support physical distancing and enhanced office disinfection
- Segment patients based on risk and patient preference and implement triage protocols to route them to the right channel to limit risk exposure and optimize practice capacity
- Proactively communicate with patients about how they will be kept safe and the importance of chronic care continuity
- Execute a pipeline conversion plan to reschedule appointments/procedures that have been postponed/cancelled
- Fully integrate the permanent use of telehealth into patient care delivery and reimbursement
- Adjust practice staffing models based on volumes of in-person care and the need to manage patient flow differently
- Support staff emotional wellbeing, paying extra attention for signs of exhaustion, depression, stress and other similar issues and putting mitigation strategies in place
- Introduce tracking systems to meet advance payment and loan provisions
- Develop contingency plans for how to navigate upcoming COVID-19 surges (rapid-cycle relapse/recovery)

NEQCA believes our Network has a singular opportunity to redefine what success means and to capitalize on the spirit of partnership and collaboration that has defined our work during the last 60 days. We may not have answers about COVID-19's scope, duration and relapse cycles that will inevitably occur. However, uncertainty should not dissuade us from taking decisive action to sustain and improve a thriving Network in all the ways summarized above.

All of us at NEQCA Central deeply admire all that our Network partners continue to do for our patients and communities. Your tireless dedication does not go unnoticed – and is truly appreciated.

Please visit the NEQCA COVID-19 website for additional information or call your Account Manager at any time. We are here for you.

Joseph Frolkis, MD, PhD
NEQCA CEO and President

Quick Start Guide

Here are the top seven recommendations to help you begin planning to safely and effectively reactivate your medical practice while COVID-19 remains prevalent. The recommendations have been developed in accordance with the Massachusetts Department of Public Health Guidance Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals). *Appendix A*.

Infection Control

- Educate yourself and your staff about infection control
- Set your practice's infection control policies and procedures
- Secure reliable access to necessary materials (e.g., Personal Protective Equipment [PPE], cleaning/disinfection materials)

Office Space Reconfiguration and Workflows

- Pre-visit COVID-19 screening questions, with confirmation call
- Office signage/Patient flow
- Waiting rooms and staff gathering areas: Chair spacing/masks, tissues, sanitizer
- Contactless registration and payment

Schedules

- Segment the day: Infectious or not? Telehealth vs in-person visits?
- Build in extra time for PPE, room cleaning/disinfection, to avoid patients meeting in the halls
- Which patients need to be seen first? How to convert scheduled in-person visits to telehealth?

Telehealth

- Consider/reconsider your telehealth platform choice
- Think about the balance between telePHONE (audio only) vs teleHEALTH (audio/video) visits
- Use telehealth for as wide a variety of use cases as possible
- Utilize your support staff optimally for telehealth support
- Optimize your technology for telehealth
- Assure you are coding and billing optimally for telehealth visits

Quick Start Guide (continued)

Reassuring Staff, Patients, and Families

- Proactively communicate to your patients and staff: “We’re making it safe for you”

Human Resources Considerations

- Focus on supporting your colleagues through this difficult time
- Update staff job descriptions and schedules
- Introduce daily symptom screening
- Establish criteria for exclusion from work
- Initiate cross-training for essential skills / cross-coverage with other practices

Financial Sustainability

- Plan for short-, medium- and long-term
- Consult with experts: accountant, lawyer, tax advisor
- Periodically reassess how performance matches plans and adjust accordingly
- Stay current with regulations and changing payer rules and fee schedules
- Maximize revenue via optimized billing and coding while maintaining good compliance
- Pay attention to changing payer mix and how it may affect your revenue projections
- Know and cultivate sources of capital
- Understand your agreements (grants, loans) and their conditions
- Make sure your practice ramp-up plan is consistent with your cash flow projections

Infection Control

Personal Protective Equipment

Appendix B, Section A3

Providers and staff must follow these guidelines for effective PPE use in the ambulatory setting:

- **Universal enhanced droplet precautions** (with all patient clinical contacts)
  - Patients should not be seen unless there are sufficient masks and gloves for all staff who need to approach patients within 6 feet *(Appendix B, Section B1)*
  - Eye protection is preferred but may be omitted for low-risk encounters (patients without symptoms of COVID-19, no recent high-risk exposures, no expectation of spatter or splash) if the supply is limited
  - Gowns are not necessary for most ambulatory encounters

- **Importance of different PPE items**
  - **Mask**: Simple medical mask (e.g., surgical mask, procedure mask) should be worn in any clinical encounter involving an approach within 6 feet of a patient. Click here for guidance about how to use a mask.
    - Please note: A N95* or equivalent mask is NOT needed in the office setting, except for aerosol-generating procedures *(Appendix C)*, which should not occur in the office setting while COVID-19 is a concern. (Nebulizer treatment is the only common aerosol-generating procedure in an office setting.) *(Appendix B, Section B1b)*

  - **Gloves** (exam gloves; sterile gloves if clinically necessary)
    - Hand hygiene must be performed before and after glove use

  - **Eye protection** (less important than mask): Anything that covers the eyes, prevents droplets from getting in, and doesn't compromise vision is acceptable
    - Ordinary eyeglasses offer some protection
    - Safety glasses add more protection (shields above, below and on the sides)
    - Goggles which seal to the face. The use of safety or ski goggles is acceptable if you can see through them appropriately and if they can be cleaned and disinfected.
    - Face shield—disposable or cleanable/reusable—offers maximal protection
    - Eye protection must be worn (along with an N95 mask) for aerosol-generating procedures

** N95 confers no additional protection without appropriate fit testing (done once, to ensure a given brand/size of N95 mask CAN fit that wearer correctly, training to ensure wearer knows how to put it on and wear it correctly) and fit checking (each use, to make sure there is a tight seal).*

Infection Control (continued)

- **Gown**
  - Not necessary for most ambulatory uses; should be used if significant splash or splatter is expected (irrigation; incision of abscess; percutaneous sampling of body fluids)
  - Gowns should be worn for one patient only and then removed for disposal or laundry
  - Single-use gowns should not be cleaned or sanitized for reuse

- **Extended use of masks and eye protection with multiple patients** *(Appendix C)*

- **Masking patients**
  - Patients should be masked prior to (or upon) office entry whenever possible, ideally with a simple medical mask, or with their own fabric mask or mouth/nose covering if supplies of medical masks are limited

- **Non-medical grade PPE**
  - Homemade PPE should not be used for patient clinical encounters

- **PPE for non-patient-facing staff**
  - When the supply of medical masks is limited, homemade masks may be used for roles without face-to-face patient contact <6 feet, to reduce transmission between staff when social distancing (>6 feet) is not possible
    - Social distancing is always preferred when possible *(Appendix B, Section B5)*

- **PPE tutorial videos (courtesy of Tufts Medical Center)**
  - **Best practices for donning and doffing different types of PPE**
  - **A guide to best practices while wearing Tier 1 and Tier 2 PPE**

Infection Control (continued)

Cleaning and disinfection

Appendix B, Section D5

Office cleaning and disinfection protocols

- Visible soiling should be **cleaned first before disinfection** as dirt and organic matter will interfere with the disinfection. Any disinfectant has a required contact time or dwell time for the surface to remain wet with the disinfectant solution before wiping up. Disinfectants should contain any one of the following active ingredients:

Ingredient	Dwell time
Benzalkonium (e.g. Lysol)	3 min
70% alcohol (isopropanol or ethanol)	30 sec
Hydrogen peroxide (standard 3%, undiluted)	1 min
Chlorine bleach (Sodium hypochlorite, diluted 1:50)	1 min
Any other disinfectant EPA-approved to inactivate the coronavirus	

- High-touch surfaces in the exam room or in any procedure room should be disinfected after every patient. These include the exam table, chair, doorknobs, light switch, faucets, and anything else the patient likely touched during the visit. These surfaces should also be cleaned with a standard surface cleaner whenever visibly soiled and at the end of the day, along with other high-touch surfaces like touch screens and keyboards. High-touch surfaces in waiting room, staff areas, and any common areas should be disinfected twice a day. Floors should be cleaned at the end of every day with usual cleansing agents.

Other supplies

- Plastic keyboard covers should be placed on computers to allow cleaning and disinfection. Inexpensive plastic sheets may be purchased that conform to standard computer keyboard layouts. The plastic aids keyboard disinfection because keyboards themselves generally may not be treated with liquids.

Infection Control (continued)

Provider and Staff Health

- **Health assessment – Providers and staff should be required every day they arrive at the office to attest that they have no symptoms** suggestive of COVID-19 (e.g., fever, chills, cough, shortness of breath or difficulty breathing, sore throat, muscle aches, vomiting or diarrhea, new loss of taste or smell) *(Appendix B, Section B3)*

  OR

  - If they do have symptoms consistent with COVID-19, they can be tested in the same fashion as patients if tests are available – either in the office or via their own health care provider,
    - If positive, they can either be:
      - Retested after symptom resolution until they meet the test-based return to work criteria,
      - OR follow the symptom-based criteria
    - If negative or not tested, they can follow the symptom-based criteria for return to work

  Either way, **staff may not return to work until they are cleared according to the CDC/DPH criteria**.

  Currently, there are no **recommendation for COVID-19 testing of asymptomatic staff**.

  If for some reason an asymptomatic staff member is tested, they may follow **CDC/DPH criteria** for clearance as well.

- **Infection Control Education for Staff –** Patient confidence depends on consistent application of infection control procedures, communication and staff readiness to answer questions and explain procedures. Staff must be educated on rationale for infection control and its practical application.

Infection Control (continued)

Miscellaneous

- Signage – Display signage to designate patient care areas (e.g., "Patient Care: PPE Required") and non-patient care areas (e.g., "Non Patient Care: No PPE Except Masks").

- Shared Food – No **shared** food should be allowed in non-patient care areas (e.g., candy bowl – even wrapped candy can be an infection vector). As usual, no food should be allowed in patient care areas.

- Do not wear dangling items such as neckties and necklaces as they may transfer organisms from one patient to another.

- Direct patient care staff to be "bare below the elbows" – short sleeves, no watch or jewelry – to facilitate good hand hygiene.

- Staff members within non-patient care areas should maintain a >6-foot distance between them whenever possible. When it is not possible, both staff members should be masked. *(Appendix B, Section B5)*

- The number of health care personnel within a room while care is being rendered should be the minimum needed for that care, in order to reduce potential exposures to COVID-19 *(Appendix B, Section B2)*

Office Space Reconfiguration and Workflows

Office Space Reconfiguration

Design/re-design office space to maximize physical distancing between patients and office staff.

Seating Area Guidance

- Allow for at least one wheelchair location.
- Limit the number of seats in waiting area to ensure minimum of 6 feet distance in every direction. Remove extra chairs, and store elsewhere if possible. Turn chairs around to face the wall if removal is not possible.
- Place Infection Control Stations containing tissues, masks, and hand sanitizer as individuals enter/approach the waiting rooms and throughout waiting rooms for easy access
- Eliminate high-touch items in waiting areas and countertops. All loose materials (literature, business cards, magazines, toys, etc.) should be removed as they can be vectors of infection. Such materials are not needed as patients should no longer spend substantial time in waiting areas.

Reception Area

- If reception desk is not enclosed, consider Plexiglas barrier to separate staff from patients.
- Place markings on floor as a guide for patients to stand back from desks or staff.

Check-in/Check-out process redesign

- Complete contactless check-in and check-out over the phone (or online) to minimize contact between patients and office staff. Include registration, filling out forms, and payment.

Exam rooms

- Keep relevant items in exam room when possible, so patient doesn't need to leave (e.g., scale).

Staff Areas

- Set-up conference rooms, break rooms and/or kitchen areas for safe social-distancing layout. Make sure sanitizer, tissues, masks and disinfectant wipes are all handy within these areas.
- Remove extra chairs to support social distancing (similar to waiting room guidance)
- No shared food should be allowed (e.g., candy bowl – even wrapped candy can be an infection vector).

Office Space Reconfiguration and Workflows (continued)

Corridors and entryways

- If available, consider separate entrances for sick and well patients or for patient entrance and exit.
- If possible, create "one way" paths through hallways (with suitable signage) to minimize exposures.

Directional and safety signage

Prominently display directional and safety signs in the following locations:

- All entrances/exits and hallways (to guide movement in one direction through office if possible)
- Waiting rooms
- Elevators
- Floors to maintain social distancing
- Place signage throughout the office for patients and staff with instructions on wearing masks, one-way flow through hallways, etc.
- Place signage to designate patient care areas (e.g., "Patient Care: PPE Required") and non-patient care areas (e.g., "Non Patient Care: No PPE Except Masks").
- Signs should also remind of respiratory hygiene, e.g. "Please keep your mouth and nose covered at all times"; "If you need a mask, ask any of our staff"; "Cover your cough", and indicate the location of infection control stations with masks, sanitizer and tissues.
- Encourage staff to use the stairs when possible while moving between floors to free up the space in elevators for patients.

Ready-made signage is available from Ricoh and DGI Communications for purchase.

Scheduling and Patient Prioritization

Modify patient schedule to incorporate telehealth visits, assure appropriate physical distancing between patients, and maximize time available to appropriately clean exam rooms and equipment. Proactively determine which patients require in-person appointments and which patients may be effectively managed with telehealth.

Office Space Reconfiguration and Workflows (continued)

Staff scheduling

- If multiple providers are in a practice, consider establishing a staffing schedule where some providers remain at home to conduct telehealth visits and others are in the office for in-person consults. This will minimize the numbers of providers and staff in the office at once.

- Consider expanding office hours to allow for minimum number of staff, providers, and patients in office space at any time.

Patient scheduling

- Consider conducting telehealth well-patient visits in two parts:
  - First, with telehealth visit for all parts of visit that can be successfully completed virtually and then second, schedule an in-person visit for anything requiring the patient's physical presence (e.g., brief directed exam, immunizations, labs, etc.). This will minimize the amount of time patients are in the office.
  - Consider whether the in-person portion could be done by a single person even if not the normal workflow to reduce potential exposures, PPE use, and time involved in PPE donning and doffing (e.g., if a physical exam is necessary, have the provider do the exam and the immunizations, even if the latter are normally done by staff member.)

- Consider conducting immunization clinics during normal appointment hours, interspersed with other patients when designated physical space is available, or outside normal hours in a drive-by format where patients do not exit their cars, to reduce exposure.
  - Plan flu immunization clinics now, including ordering ample doses of vaccine. High vaccine uptake should be expected this year.
    - Consider all formulations that may be needed (including intranasal for needle-phobic and some pediatric patients, high-dose for elders, and egg-free formulations for patients with severe current egg allergy.)

Office Space Reconfiguration and Workflows (continued)

Patient scheduling (continued)

- Discourage any "drop in" appointments and only see patients when scheduled.
  - Be prepared to manage patients who do show up despite these guidelines
- Lengthen appointments to allow time for room cleaning and disinfection, PPE changes etc.
- Schedule sick appointments and anyone with active COVID-19-compatible symptoms, regardless of reason for visit, during one half of the day, and physicals and follow up appointments during the other half of the day, to reduce exposure of well patients.

Patient Prioritization

- Assign staff to review any patient appointments that were canceled/postponed in March/April
  - Clinician or nurse should review those appointments to designate clinical priorities
  - Conduct outreach to reschedule canceled or postponed appointments as either telehealth or in-person appointment, as appropriate
- Clinical priorities beyond active issues
  - High-risk deferred care based on acuity or risk profile (e.g., patients whose workup for cancer-suspect findings were interrupted by the pandemic)
  - Preventive care
    - Routine pediatric care and immunizations
    - Screenings for high risk patients (e.g. breast cancer and colon cancer screening)
  - High risk or high acuity BH/psychosocial issues, SUD/MAT, evaluation for suspected child abuse or domestic violence
  - Evaluation and diagnostic workup of high-risk, high urgency findings (blood in the stool, breast lump, concerning skin lesions)
  - Procedures that if deferred might lead to serious potentially avoidable outcomes (malignant skin lesions, tooth extractions for abscess)
  - Follow-up for chronic diseases
  - Placement of long-acting reversible contraception
  - Immunizations
- Patients who have difficulty with technology (and thus for whom telehealth visits may not be effective) should be prioritized for in-person visits.

Office Space Reconfiguration and Workflows (continued)

Non-patient visitors and patient companions

- People who accompany patients should be asked to not enter the office if possible. They should remain with patients only if the patient needs them during the visit.
- Limit office visits by non-patients (e.g., supplies, vendors, salespeople). Clearly post signs for non-patients with instructions for how to schedule phone or video conferences. Designate times outsides of normal patient-care hours for non-patient visitors who must physically enter the practice to minimize exposures to and from patients.

Visit Workflows

Confirmation calls

Contact patients no more than 48 hours before scheduled telehealth or in-person appointment to conduct check-in process (confirm appointment, verify insurance, collect copayment/payment, demographic information).

Confirming in-person visits

- Orient patient to new office procedures
- Request patients to arrive wearing a clean mask
- Request that patients arrive alone, if possible, or minimize the number of people accompanying them. Offer speakerphone presence for family members or interpreters. If patient needs to be accompanied, request that companion wears a clean mask as well.
- Screen patients and necessary companions for COVID-19 symptoms:
  - **Fever**
  - **Cough**
  - **Shortness of breath or difficulty breathing**
  - **Chills**
  - **Muscle aches**
  - **Sore throat**
  - **New loss of taste or smell**
  - **Vomiting or diarrhea**

  If any COVID-19 symptoms are present, clinician should triage (including whether the patient can/should be managed by telehealth). If an in-person visit is required, note the patient's possible COVID-19 status on the schedule.

Office Space Reconfiguration and Workflows (continued)

Before in-person visits

- Distribute any paperwork electronically (or through US mail) for completion and submission prior to appointment as needed.

Patient Check-In, Rooming, and Check-Out Workflow

- Modify current workflows to minimize the amount of physical contact between staff and patients at check-in, rooming and check-out.

Patient Arrival/Office Flow

- Direct patients to wait in their cars or other areas before entering building for appointment
- Have staff member wearing a procedure mask greet patient at car or entrance.
  - Have small supply of procedure masks for patients and necessary companions not arriving with their own.
- Direct patient to an exam room upon arrival, without stopping in waiting room.
- Any check-in protocols not already completed in advance should be completed in exam room (e.g., collect co-pays). Use contactless means when possible.

After all visits

- Before referring patients for any follow-up services (including imaging, lab testing, ancillary therapy services, or regular clinical consultations) verify the facility is open, accepting patients, and providing the needed services.
- For frequently used services, it may be helpful to check with the preferred ancillary provider on a regular basis (e.g., weekly), until full service is restored.

After in-person visits

- Direct patients to remain in their exam rooms until a staff member instructs them to leave (to minimize the opportunity to encounter other patients in hallways or waiting area).
- Conduct check-out procedures (e.g., payments, scheduling follow-up appointments, etc.) in the exam room, over the phone, or online after the appointment.

Telehealth

Many physicians have either implemented or expanded the use of telehealth to continue seeing patients while avoiding exposing anyone to infection risk. Practices that have not yet implemented telehealth should consider doing so immediately. While practices should make telehealth an integral part of patient care delivery, offices can begin to increase the proportion of visits done in-person.

Practice Set Up

Choice of platform

- Whether you are initiating telehealth now or continuing your services, it's a good time to review your telehealth options and to select a HIPAA-compliant platform (if you are not already using one). NEQCA has developed a short list of telehealth solutions that are HIPAA compliant and those that are not. While the HIPAA waiver is still active as of the preparation of this guide, practices must be at the ready for when it expires.
- Your office may want to consider having two platforms available – a primary and a backup telehealth solution.

Inform your patients about your practice's telehealth policies.

- Send a portal message (electronic communication) to all patients about telehealth appointments being offered by the practice.
- Update additional modes of communication including your office "on hold" messages, social media channels, website and a brief mention of telehealth at the bottom of every portal message
- Inform your Answering Service about your use of telehealth

Technology

- Consider having separate screens or devices for telehealth and the EHR, unless telehealth is integrated into the EHR
- Some telehealth solutions offer the ability to add a third party such as a patient's family member or an interpreter. Investigate whether your platform has this feature and how to use it.

Staff

Consider staff roles in the office related to incorporating telehealth permanently in your workflow.
(See **How Staff Can Support Telehealth**, page 20)

Telehealth (continued)

Training

Familiarize yourself with telehealth workflows by conducting several encounters with test patients (with trainer or staff if available). Visit NEQCA's Telehealth Services website for guidance about how to optimize telehealth visits.

Scheduling and EHR Set-up and Considerations

- Create an EHR telehealth note template to capture necessary components of documentation
- Create visit types in your schedule for telehealth
- Develop a new daily schedule template that includes telehealth visits
- Decide if you prefer to cluster telehealth visits or intersperse them with in-person visits. Many practices find it helpful to schedule blocks of time (two or three hours) exclusively for telehealth. Staying in one modality at a time may be easier than transitioning back and forth.

Selecting patients for telehealth visits

Visit Types Which May Be Suitable for Telehealth

- Develop a framework for your office about which types of visits are appropriate for telehealth
- Assess and triage every appointment to see if can be done by telehealth
- In addition to a regular office visit that could be conducted via telehealth, consider the following types of visits as examples of the many may be suitable:
  - Post hospital or SNF discharge visit
  - Transitional Care Management (TCM) visit
  - Medicare annual wellness visit (which is an opportunity for a "Goals of Care" conversation, a review of medical issues, to update patient conditions for risk adjustment, and to make specialist referrals if needed)
  - Counseling, including smoking cessation, nutrition, emotional support, etc.
  - Behavioral health
  - Chronic disease management

Telehealth (continued)

Filling your schedule

- Proactively and recurrently review your future schedule to convert appropriate visits from in-person to telehealth
- Clinical staff should review visits by that were cancelled due to the pandemic to see if they should be reinstated and if they can be done via telehealth
- Ensure that office triage protocols are revised to include determining which patients are appropriate for a telehealth vs. in-person visit
- Develop a plan for proactive targeted patient outreach. Prioritize those patients considered high risk with significant chronic disease who have not been seen recently as well as members without office visits.

How Staff Can Support Telehealth

- Before and/or at the beginning of the visit
  - Well in advance: Make sure patients' technology is working and they know how to connect
    - If applicable, confirm that the patient has downloaded the telehealth application, set up an account, and tested the system
  - For some patients, this may be a one-time assist. For others, they may need help every visit.

- At the beginning of the visit: "Virtual rooming"
  - Be sure the patient's technology is working (able to connect)
  - Ask questions staff customarily would review during an in-person encounter
  - Have patient gather all medications and medical devices
  - Medication reconciliation (if staff skills/credentials permit)
  - Review routine preventive care that's due (cancer screenings, immunizations, etc.) and tee-up the list for the clinician
  - Set up a note template, order sets for clinicians in the EHR (if staff skill set permits)
  - Obtain vital signs if relevant and possible
    - Obtain BP if patient has an automated device
    - Obtain Pulse and O2 sat if patient has a medical grade pulse oximeter
    - Count respirations by inspection
    - Obtain temperature if patient has thermometer
    - Obtain weight if patient has a scale

Telehealth (continued)

- At the end of the visit: Checkout
  - Review clinician's instructions with the patient and be sure the patient receives an electronic copy. Provide any education material or teaching needed.
  - Scheduling:
    - Follow-up visit with the clinician/practice. An in-person visit shortly after telehealth may be requested by the clinician for brief targeted examination
    - Immunization
    - Other follow-up
    - Specialist referral
    - Testing, including imaging or other tests needing to be scheduled
  - Direct patient to specimen collection site for labs

Billing and Coding /Documentation

- Before finishing the patient encounter note, it may be helpful to run a checklist to ensure you have captured required documentation
- Understand the billing and coding guidelines for telehealth visits. NEQCA has helpful information on the Telehealth Services section of its website.

Prepare for the unexpected. Things may not go as planned, so have some contingencies. For instance, consider having your front desk call patients if you are running late.

Additional Clinical Considerations

- **Develop contingency plans to navigate upcoming COVID-19 surges** (rapid-cycle relapse/recovery)

- **Develop a strategy and timeline for resumption of effective and proactive population health management**

- **Plan for how to manage an emergency situation** (e.g., CPR/Anaphylaxis/Seizures)
  - **Practices may need to add PPE to normal procedures and supplies**

- **Patient financial stresses and insurance changes may force medication changes due to cost or formulary issues**. Be prepared.

- **Consider whether you need new or modified EHR templates**
  - Telehealth
  - COVID-19 clinical—acute, follow-up, complications

- **Consider and plan for procedures you customarily do in your office**
  - Are there any extra cleaning/disinfection steps needed for these procedures?
  - Does any procedure generate aerosols (and therefore need more/different precautions)?

- **Are there shortages of materials or medications that will force you to modify how you practice for now?**

- **Consider how to operate safely, effectively and efficiently if everyone is working remotely (i.e. nobody is physically in the office)**
  - Management of incoming information and items
    - Phone
    - Fax
    - Paper mail
    - Other electronic
    - Mail, packages, deliveries
  - Consider whether any in-person maintenance or monitoring needs to be done if prolonged physical absence from the office (e.g., monitoring temperature in vaccine refrigerators and freezers)

Reassuring Staff, Patients, and Families

A series of messages and materials have been developed to help you communicate with staff, patients and families about the steps your practice is taking to deliver safe, quality care while COVID-19 remains prevalent.

The Safe With Us campaign has been initiated among all Wellforce member organizations, including NEQCA and Tufts Medical Center. The campaign acknowledges concerns patients may have about going anywhere right now, including to a doctor's office or hospital. It urges patients not to delay care and outlines the extensive safety measures you are taking to provide a clean, safe and supportive clinical environment.

Please visit NEQCA's Safe With Us website for the following information:

Safe With Us Messages

- Talking points for your staff to reassure patients and families
- Message for your patient portal, in emails, on social channels, and your practice website

Safe With Us Materials

- Safe With Us icon to display on your website, social channels, and patient portal
- Safe With Us window cling to display on doors and windows
- Safe With Us posters to display in common areas and exam rooms
- Safe With Us postcard to mail to patients or use as an appointment card

Safe With Us at Tufts Medical Center and Floating Hospital For Children

- Virtual Tour: Tufts Medical Center
- Virtual Tour: Floating Hospital For Children

Reassuring Staff, Patients, and Families (continued)

Additional Safety Resources for Patients

Hospitals are seeing sharp declines in the numbers of people seeking care for heart attacks, stroke, accidents and infections. Please reach out to your patients to remind them of the importance of seeking timely care. Consider posting these resources to your website, social channels, and patient portals.

- VIDEO PSA: A Message From Hospitals: Don't Avoid Emergency Care
- VIDEO PSA: Children's Trauma
- VIDEO PSA: Stroke and Heart
- VIDEO PSA: Medical Emergencies

Other Resources

NEQCA's COVID-19 website contains a wealth of information that you can email to patients, post to your website or deliver through your social media channels, including:

- Mask Do's and Don'ts flier for display in your practices or posting to your website
- How to safely cover your face outside of the home video for posting to your website and social channels
- How to Correctly Put on/Take off a mask (adult and child videos)
- 10 Things You Can Do to Manage Yourself at Home for your website and social channels

Human Resources Considerations

As practice volume increases, employees who were previously furloughed will need to return to work. It is necessary to prepare for their return and to make necessary adjustments to their job responsibilities and schedules.

Staffing Schedules, Roles and Responsibilities

- Staff members should be reminded they were not laid off or terminated. Furlough status is temporary. Employees are only eligible for unemployment benefits when work is not available.
- For practices with more than a few staff, it will be necessary to anticipate the gradually increasing workload and the likelihood of different staffing needs for telehealth and in-person appointments, so staff may return to the practice on an "as needed" basis.
- Office staff returning from furlough or reduced hours should be familiarized with new office procedures and workflows. They will need to be reassured about their safety and the safety of patients and educated in infection control.
- Realign support staff schedules to match changes in practice hours or patient schedules. Staffing ratios for telehealth sessions may be different than for in-person care.
- Update job descriptions to reflect expectations for how telehealth and in-person visits are to be conducted.
- Create in-person and virtual options for infection-control training.
- Continue to utilize remote work wherever practical. Minimizing the number of staff members in the office will reduce exposures and facilitate physical distancing. Be clear about expectations for hours worked, responsibilities, responsiveness, and deliverables before remote work is determined appropriate.
- Make contingency plans for employee illness or illness in employees' family members that would require them to stay home. Planning could include extending hours, cross-training current employees, or hiring temporary employees.
- Focus on maintaining the health and safety of clinicians, staff and patients. For information regarding appropriate management of providers or staff with symptoms, positive test results, or exposures, see the **Infection Control** section starting on page 7.
- Implement sick-leave policies that are non-punitive, flexible, consistent with public health policies and that allow ill staff to stay home. Staff should be reminded to not report to work when they are ill.
- Do not require a health care provider's note for employees who are sick with respiratory symptoms before returning to work.

Human Resources Considerations (continued)

Clinician and Staff Emotional Wellbeing

The emotional wellbeing of clinicians and staff are highly important during these uncertain times.

- Remember to reassure staff that their health and safety, and that of their families, is very important to your practice. By implementing the infection control procedures in this guide you are demonstrating your sincere commitment to their wellbeing.

- Consider individual staff health and the potential for increased risk (e.g., age, underlying health conditions). If possible, offer staff members at increased risk the opportunity to work remotely or to modify their roles to allow for additional physical separation or reduced clinical interaction with patients.

- Talk openly with your staff about their fears or concerns. If questions or circumstances arise that you can't immediately address, seek expert input. Honest and open dialogue with staff will increase their trust and comfort during uncertain times. NEQCA may be able to put you in contact with mental health professionals who can help.

Many wellbeing resources are available on NEQCA's website.

Financial Sustainability

Physician practices must adapt to providing patient care while COVID-19 is still in the community. Such changes require practices to develop a short- and long-term financial plan with consultation from experts, a defined plan for revenue changes, and a focus on cash-flow.

Importance of financial planning

It is very important to have a clear picture of your practice's financial goals for the short-, intermediate-, and long-term. This will ensure that you are asking the right financial questions and building the right operational plan to get there. When you set financial goals, you have something to measure your financial performance against. Consider these following steps for a successful practice reactivation.

Financial Sustainability (continued)

Consult your team of experts

- Each business owner should have a team of trusted advisors. Generally, a lawyer, an accountant, and a tax advisor represent a good core team.
- Reach out to your advisors to ask for assistance developing short-, intermediate-, and long-term financial plans.
- If you want to manage the expenses of your expert team, you can independently develop your financial plans and then ask your advisors to review and modify your plans, as necessary. Your team will ask the right questions to be sure you have covered all your bases and your expectations are realistic and achievable.

Build Short, Intermediate, and Long Term Financial Plans

- Building one-month, three-month, six-month, one-year, and five-year financial plans that consist of both income statements and cash-flow projections. Be sure to document the assumptions that you are using when building out these projections. These will be important when asking your advisors for assistance.
- Build time into your schedule for regular financial reviews. It will be critical to regularly assess how your actual financial performance is tracking to your forecast. Regular reviews will allow you to be agile and change your business practices as necessary to successfully execute on your plan.

Revenue planning amid uncertainty

Revenue cycle is the financial lifeblood to a practice's profitability. When working through your financial planning, it is important to be clear about your assumptions related to the practice's revenue cycle. You must periodically reassess, as uncertainty becomes dampened and clarity emerges regarding the reimbursement landscape going forward.

- **Consult your revenue cycle experts**. The health care reimbursement landscape continues to increase in complexity, with multiple local and national payers implementing different payment rules and fee schedules across various product lines. Staying on top of market movements and understanding required documentation to bill for services – as well as how to compliantly optimize your reimbursement through billing and coding – requires expertise and time commitment. As you reactivate your practice, prioritize regular reviews of revenue-cycle information from your trusted partners (vendors, LCO staff, NEQCA). Each will be invaluable in advising you about evolving changes in the payer community.

Financial Sustainability (continued)

- **Payer Mix Considerations**. The economic ramifications of COVID-19 will have broad and lasting impacts on unemployment. A shift in payer mix away from commercial plans and toward government plans is anticipated. It is important that you factor this into your financial planning assumptions.

Sustaining Cash Flow

When planning your reactivation efforts, strong cash planning will be essential. Physician practices have been eligible for many financial relief efforts in recent months. It is important to monitor all the sources of capital available in various scenarios related to the infection curve and the economy.

- **Cultivate relationships with various sources of capital**. In times of unexpected stress, strong banking relationships are extremely helpful. Many practices have taken advantage of the Payment Protection Program loans by working with either new or existing banking relationships. It is prudent to assess your banking relationships and how they have performed in the first round of PPP loans. Take note of who you would work with in the future should additional funding become available or be needed to sustain operations.

- **Understand all agreements you currently have in place**. As you reactivate your practice, be sure that you understand all requirements related to funding provided to you by federal or state governments. Much of the funding requires attestations and reporting to retain grant funding or to have loans forgiven. Materials on the NEQCA website will be helpful with this process.

- **Understand the impact of revenue projections** on both your fixed- and variable-cost structures. When reactivating your practice and developing financial assumptions, account for the end dates of any temporary funding that you have received. If you received any prepayments for services, be sure to factor repayment schedules into your financial projections. You may need to consider a phased reactivation approach to align with your cash-flow capacity until your assumptions are confirmed or necessary growth in your cash flow occurs. Do not hesitate to reach out to strategic vendors and any group you spend considerable money with to ask for relief in payment terms or to restructure deals in light of current economic times. Remember, it is in the best interest of your suppliers to ensure your success.

APPENDIX A

Massachusetts Department of Public Health Guidance Reopen Approach for Health Care Providers

(Providers that are Not Acute Care Hospitals)

NOTE: This guidance has been updated as of May 25, 2020 to provide the following clarifications:

- **Statewide bed capacity calculation methodology**
- **Attestation process for health care providers with multiple locations under common control**

Preamble and Purpose

On March 15, due to the public health emergency arising from the outbreak of COVID-19, the Baker-Polito Administration ordered that, in order to protect patients and health care personnel and to conserve personal protective equipment (PPE), hospitals and ambulatory surgical centers postpone or cancel any nonessential, elective invasive procedures.[1] This Order is consistent with the recommendation of the Centers for Medicare & Medicaid Services (CMS) that all elective surgeries and non-essential medical, surgical, and dental procedures be delayed.[2]

While hospitals and health care providers have been providing care to COVID-19 patients and other patients requiring emergency care and have expanded use of telehealth, many healthcare services beyond elective invasive procedures have also been delayed and deferred during the public health emergency. There is a need to begin to provide certain deferred care to patients that cannot be provided remotely via telehealth, while also recognizing that telehealth may not be feasible or clinically appropriate for all patients. The Baker-Polito Administration has determined that such care can begin to be provided in Phase 1: Start of the Commonwealth's reopening process, subject to guidance of the Department of Public Health (DPH).

DPH issues this guidance for how health care providers that are not acute care hospitals[3] can begin in-person provision of a limited number of additional, necessary services and procedures without jeopardizing health system capacity or the public health standards that are essential to protecting health

[1] Elective Procedures Order. Massachusetts Department of Public Health (March 15, 2020): https://www.mass.gov/doc/march-15-2020-elective-procedures-order. Memorandum: Nonessential, Elective Invasive Procedures in Hospitals and Ambulatory Surgical Centers during the COVID-19 Outbreak. Massachusetts Department of Public Health (March 15, 2020): https://www.mass.gov/info-details/covid-19-state-of-emergency.

[2] Press Release: CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response. CMS (March 18, 2020): https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental.

[3] As used in this document, "health care provider" or "provider" means those providers that are not acute care hospitals. DPH has issued separate guidance for acute care hospitals. See Massachusetts Department of Public Health (DPH) Reopen Approach for Acute Care Hospitals guidance.

care workers, patients, families, and the general public. This guidance does not apply to emergency care, which has been ongoing and will continue without limitation. DPH recognizes the importance of ensuring that this guidance promote equitable access to care across all communities and patient populations, including low-income communities, children, and individuals with disabilities.

The initial and ongoing implementation of this guidance is contingent on Massachusetts meeting a range of relevant capacity and public health metrics. Ongoing performance on these measures will inform additional reopening decisions for future phases.

II. Statewide Capacity Criteria for Entering Phase 1: Start

Consistent with a cautious and deliberate reopening strategy, DPH has determined that health care providers will be eligible to enter Phase 1: Start as follows.

Beginning on May 18, 2020, community health centers (CHCs)[4] that meet the Public Health and Safety Standards described in Section IV of this document will be eligible to move into Phase 1: Start if the following statewide capacity criteria are met.

1. **Intensive Care Unit (ICU) Bed Capacity:** The 7-day average of the number of available, staffed adult ICU beds statewide must be at least 30% of total staffed adult ICU beds (including staffed surge ICU beds).

2. **Inpatient Bed Capacity:** The 7-day average of the number of available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) statewide must be at least 30% of total staffed adult inpatient beds (including staffed surge beds).

DPH will assess progress against the statewide capacity criteria based on the data reported daily by hospitals in WebEOC, using a 7-day average, and will announce when the statewide capacity criteria have been met on or after May 18, 2020[5]. Prior to beginning in-person delivery of any Phase 1 procedure or service between May 18, 2020 and May 24, 2020, the CHC must complete and submit to

[4] For purposes of this guidance, the term "community health center" shall include Federally Qualified Health Centers and hospital-licensed community health centers.

[5] To calculate statewide bed availability, based on the data reported daily by hospitals in WebEOC, DPH will: (a) calculate the numerator for each day: sum the number of adult medical/surgical and ICU patients (i.e., occupied beds) across the state. Then, (b) calculate the denominator for each day: sum the total adult medical/surgical and ICU staffed beds (including staffed surge) across the state for the current day. To calculate the occupancy percent, DPH will (c) divide the numerator by the denominator: the summed number of patients (i.e., occupied beds) by the summed total number of staffed beds (including staffed surge). To calculate the availability percent (d), DPH will subtract the occupancy percent from 1. To calculate a 7-day average, (e) DPH will calculate the bed availability rate for the current day, and using the same methodology calculate the rate from the previous 6 days, and take an average of the 7 rates. The ICU criteria is calculated using the same methodology, but using only adult ICU patients and staffed ICU beds (including staffed surge). For the purpose of this guidance, staffed surge beds (ICU or inpatient) means those beds that are currently staffed or that the hospital can staff within 12-24 hours. Unstaffed surge beds, i.e., those that can be made available within 72 hours, should not be included.

DPH the Health Care Provider attestation form, and post the completed form on the CHC's website, as detailed in Section V.

Beginning on May 25, 2020, health care providers (including CHCs that have not yet moved into Phase 1) that have met the Public Health and Safety Standards described in Section IV of this document will be eligible to move into Phase 1: Start if the statewide capacity criteria continue to be met. Prior to any health care provider beginning in-person delivery of any Phase 1 procedure or service in-person on or after May 25, 2020, the health care provider must complete the Health Care Provider attestation form, as detailed in Section V. The completed attestation form must be kept on file by the health care provider for inspection by DPH upon request. Health care providers with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance leader has clinical and operational control over the other locations.

DPH will continue to monitor statewide bed availability and may require that health care providers suspend or limit provision of any of the procedures and services described in Section III of this guidance based on its determination that statewide bed capacity is deemed to jeopardize the health system's ability to respond to patient demand.

III. Guidance on Recommended Procedures and Services

Once the statewide capacity criteria have been met, in Phase 1: Start, health care providers that have met the public health and safety standards described in Section IV may begin in-person delivery of certain procedures and services that, based on the health care provider's clinical judgment, constitute:

1. High-priority preventative services, including pediatric care and immunizations, that cannot be provided safely and appropriately via telehealth, recognizing that telehealth may not be feasible or clinically appropriate for all patients.

2. Urgent procedures and services that cannot be delivered remotely and would lead to high risk or significant worsening of the patient's condition if deferred.

Health care providers should consider the following examples in making their determinations.

Examples of Services That Can be Delivered In-Person in Phase 1 *Examples below are illustrative only and not comprehensive. Providers should use their clinical judgment in determining which services are appropriate for patients consistent with the criteria.*
• Pediatric visits, high priority preventative visits that lead to high risk if deferred, e.g., immunizations, screenings for at-risk patients (such as colonoscopies for individuals with family history of cancer), or chronic disease management visits for high-risk patients
• Diagnostic procedures for high risk patients that lead to high risk if deferred, e.g., colonoscopy for blood in stool, biopsy for concerning lesions and potential cancers, urgent labs, tests, blood draws
• Exams for new concerning symptoms requiring physical exam, e.g., breast lump, post-menopausal vaginal bleeding, or individuals at high-risk of chronic diseases, such as poorly controlled diabetes
• Medical procedures that if deferred lead to substantial worsening of disease, e.g., excision of malignant skin lesions, orthopedic procedures for significant functional impairment
• In-person visits for high risk behavioral health and/or social factors, e.g., domestic violence, child abuse or neglect assault, substance use disorder treatment including Medication Assisted Treatment
• Dental procedures that are high risk if deferred, e.g., tooth extractions for abscess
• Rehabilitation for which delay would lead to significant worsening of condition and long-term prognosis, e.g., for post-stroke patients or severe traumatic injuries
• Placement of implantable contraception

As health care providers begin planning to provide deferred or delayed care, they should develop a strategy to identify the patients and services that, based on the clinical determination of the provider, are most urgent. Such strategy should incorporate considerations such as chronic illness, disability, or risk factors related to the social determinants of health, without regard for a patient's insurance type.

Because of unique considerations for children, consistent with the requirements of this guidance, in Phase 1, health care providers may resume routine pediatric care, including in-person well child visits. Missed scheduled vaccines should be prioritized. Providers should continue screening for social needs, behavioral health concerns, child abuse, and intimate partner violence.

Health care providers should also continue to provide services via telehealth to the greatest extent possible when clinically appropriate, while also recognizing that telehealth may not be feasible or clinically appropriate for all patients. Examples of services that may be clinically appropriate for telehealth include: preventative care; wellness; chronic disease management; consultations; behavioral health treatment; and pre-appointment patient screenings.

If a health care provider is unable to utilize telehealth for a patient where telehealth is clinically appropriate and the patient would otherwise be able to be served by telehealth, the provider should consider referring the patient to another provider with telehealth capabilities when appropriate. All patients should be encouraged to call their provider or urgent care facility prior to making an in-person visit, except in an emergency.

IV. Required Public Health and Safety Standards

In order to provide the services outlined in Section III in Phase 1: Start, health care providers must meet specific criteria related to: a) personal protective equipment (PPE); b) workforce safety; c) patient safety; and d) infection control. Each health care provider must develop written policies and procedures that meet or exceed the requirements of this Section or incorporate the requirements of this Section into its existing policies and protocols. Health care providers must designate a compliance leader at the highest level of the organization to ensure compliance with the clinical and safety standards outlined in this guidance.

A. Personal Protective Equipment and Other Essential Supplies

Health care providers must continue to follow the most recent guidelines issued by DPH[6] that align with the CDC as it relates to PPE usage, including any updated guidelines released subsequent to the date of this guidance. In addition, health care providers must meet the following three standards related to PPE supply.

1. Health care providers must ensure that they have adequate supply of PPE and other essential supplies for the expected number and type of procedures and services that will be performed. To meet this requirement, providers may not rely on additional distribution of PPE from government emergency stockpiles.

2. Health care providers must take reasonable steps to maintain a reliable supply chain to support continued operations.

3. Health care providers must develop and implement appropriate PPE use policies for all services and settings in accordance with DPH and CDC guidelines.

[6] Please see: https://www.mass.gov/info-details/covid-19-guidance-and-directives.

B. Workforce Safety

Health care providers must meet the following five standards related to workforce safety.

1. All staff must have appropriate PPE to perform the service or procedure and any related care for the patient. If appropriate PPE is not available to protect the health care workers involved in the patient's care, the service/procedure should be cancelled.

    a. Health care providers and other staff must wear at least surgical facemasks at all times, consistent with DPH's Comprehensive PPE Guidance.

    b. Eye protection (goggles, visor, or mask with visor) and N95 or equivalent respirator masks must be provided by the health care provider and worn by all health care workers while engaged in direct patient care for procedures with increased potential for droplet aerosolization.

2. Health care providers must restrict the number of health care workers in the treatment space to those individuals necessary to complete the service or procedure for the patient.

3. Health care providers must have a written protocol in place for screening all employees for symptoms of COVID-19 prior to entering the facility or office.

4. Health care providers must adopt policies that address health care worker safety and well-being.

5. The facility or office must ensure social distancing for providers and staff to the maximum extent possible (see Section IV.D).

C. Patient Safety

Health care providers must meet the following four standards related to patient safety.

1. Health care providers must have a process for screening patients and companions for symptoms of or known exposure to COVID-19 prior to entering the office/facility.

2. Health care providers must have policies and procedures for screening patients in advance of a service or procedure, including policies and procedures to facilitate the testing of patients for COVID-19 when medically appropriate as well as for determining whether a procedure should go forward if a patient tests positive.

3. Health care providers must develop policies permitting patient companions only in special circumstances when necessary for the patient's well-being. Special circumstances and populations may include end-of-life care, prenatal care, pediatric patients, behavioral health patients, patients with intellectual or developmental disabilities, patients with physical disabilities, or populations as otherwise identified by DPH. Health care providers must also ensure that policies address patient visitors consistent with DPH guidance. These policies must be accessible to patients seeking care.

4. Health care providers must require that all patients, companions, and visitors wear mouth and nose coverings as consistent with DPH guidance.[7] However, the health care provider may consider waiving the requirement for mask and nose coverings for patients and/or companions in special circumstances consistent with applicable guidance.

D. Infection Control

Health care providers must meet the following four standards related to infection control.

1. **Health care providers must demonstrate adherence to social distancing and relevant** guidelines from DPH and CDC regarding infection control and prevention to maintain a safe environment for patients and staff.

2. Health care providers must adopt administrative and environmental controls that facilitate social distancing, such as minimizing time in waiting areas, including by asking patients to wait outside until their appointment begins to the greatest extent possible. For any waiting patients, social distancing and face coverings must be in place.

3. Health care providers must minimize contact between patients through scheduling, such as establishing different times of day or separate space to avoid possible exposure to COVID-19.

4. Health care providers must have signage to emphasize public health measures (i.e., distancing, coughing etiquette, wearing of face coverings, and hand hygiene) and must provide access to hand sanitizer for patients and staff.

5. Health care providers must have an established plan for thorough cleaning and disinfection of all common and procedural areas, including in-between patient encounters in treatment rooms, which may require hiring environmental services staff and reducing patient hours to allow for more frequent cleaning.

[7] Please see: https://www.mass.gov/news/wear-a-mask-in-public.

V. Compliance and Reporting

Attestation Form

Health care providers seeking to deliver the services described in Section III must first attest, on a form prescribed by DPH, to meeting the public health and safety standards outlined in Section IV, to having designated a compliance leader at the highest level of the organization to ensure compliance with the clinical and safety standards outlined in this guidance, to making clinical determinations about service provision in a manner consistent with this guidance, and to making reasonable efforts to recall furloughed direct care workers to the extent possible. The attestation must be signed by the chief executive officer of the CHC and for other health care providers by the compliance leader responsible for internal compliance with these criteria. CHCs and other health care providers must maintain the signed attestation and make it available upon request of DPH at any time. Health care providers with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance leader has clinical and operational control over the other locations.

Written Policies and Protocols

Health care providers must maintain written policies and protocols that incorporate or exceed the standards outlined in this guidance for PPE and supplies, workforce safety, patient safety, and infection control. Such policies, protocols, and documentation must be regularly updated and made available to DPH upon request at any time.

Compliance

DPH will monitor and assess compliance and may require remedial action or suspension of Phase 1: Start procedures and services as warranted.

You may electronically complete this document by downloading the attestation form here.

Massachusetts Department of Public Health
Health Care Provider Phase 1 Reopen Attestation

NOTE: This attestation form has been updated as of May 25, 2020 to provide the following clarifications:

- **Attestation process for health care providers with multiple locations under common control**
  If health care providers prepared attestation using the previous version of this form, there is no requirement to update to this version.

This self-attestation form is applicable to all health care providers other than acute care hospitals and must be completed prior to performing Phase 1 services and procedures as defined in Massachusetts Department of Public Health (DPH) Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals) guidance ("DPH Provider Reopening Guidance"). The form must be signed by the provider's designated compliance leader or, in the case of a community health center (CHC) as defined in DPH Provider Reopening Guidance, the CHC's chief executive officer. Health care providers with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance leader has clinical and operational control over the other locations.

A health care provider that meets the criteria below and intends to perform Phase 1 services and procedures on or after May 25, 2020 must retain this attestation for inspection upon request by DPH.

Provider Information	
Provider Name:	
Date of Self Attestation:	
Date to Begin Phase 1 Services:	
Individual Responsible for Compliance ***Authorized compliance lead for the provider or Chief Executive Officer***	
Name:	
Title:	
Phone Number:	
E-mail Address:	

Attestation of Compliance *Mark each criteria with an "X"*	
In accordance with DPH Provider Reopening Guidance, the undersigned certifies that:	
Public Health and Safety Standards	
	The health care provider is in compliance with all Personal Protective Equipment and Other Essential Supplies standards outlined in DPH Provider Reopening Guidance.
	The health care provider is in compliance with all Workforce Safety standards outlined in DPH Provider Reopening Guidance.
	The health care provider is in compliance with all Patient Safety standards outlined in DPH Provider Reopening Guidance.
	The health care provider is in compliance with all Infection Control standards outlined in DPH Provider Reopening Guidance.
	The health care provider maintains and regularly updates written policies or procedures that meet or exceed all of the public health/safety standards outlined in DPH Provider Reopening Guidance.
Services and Procedures Provided	
	The health care provider will provide only those in-person procedures and services consistent with the DPH Provider Reopening Guidance that based on the provider's clinical judgment, constitute: (1) high-priority preventative care, such as pediatric care and chronic disease care for high-risk patients, (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, and (3) emergency procedures or services.
	The health care provider is making clinical determinations about service provision in a manner consistent with the DPH Provider Reopening Guidance.
Compliance and Reporting	
	The health care provider has designated a compliance leader at the highest level of the organization who is responsible for overseeing ongoing compliance with the standards and criteria outlined in DPH Provider Reopening Guidance.
	The health care provider will maintain this attestation and documentation of compliance, including all written policies and protocols that incorporate or exceed the standards outlined in DPH Provider Reopening Guidance for PPE and supplies, workforce safety, patient safety, and infection control, and will make such documents available to DPH upon request at any time.
	The health care provider is making reasonable efforts to recall furloughed direct care workers to the extent possible.

Certification and Attestation of Provider Readiness	
	On behalf of the provider indicated above, I certify under the pains and penalties of perjury that the above certifications are true and accurate and the provider will continue to meet the Phase 1 criteria and standards in DPH Provider Reopening Guidance. I understand that should the provider become unable to meet any of the criteria or standards in DPH Provider Reopening Guidance and contained within this form the provider must immediately notify DPH and cease performing Phase 1 services until full compliance is obtained.
Signature:	
Date:	
Name:	

APPENDIX B

TEMPLATE

Policies and Procedures for <practice name> for providing care in the COVID-19 era

A. PPE and essential supplies

1. Inventory levels are checked daily. Inflow from suppliers and usage are noted daily, of PPE, disinfectants and other necessary supplies

2. A list of alternate suppliers is maintained in case of shortage

   a. The Mass. DPH may not be considered as an alternate supplier for this purpose

3. PPE policies have been developed and implemented. Existing employees have been trained, and new employees will be trained, in accordance with these policies (See below)

B. Workforce Safety

1. If PPE inventory is insufficient for a care encounter, that encounter is not begun.

   a. Simple facemasks ("surgical", "procedure") must always be worn by staff providing patient care

   b. Aerosol-generating procedures create increased risk of infection. They should be avoided whenever possible. These procedures will not be performed routinely. If there should be a pressing need requiring such a procedure (e.g. a nebulizer treatment when inhaled treatment with a metered-dose inhaler is not possible or clinically appropriate), it will only be performed if any health care personnel in the room are wearing eye protection and N95 masks for which the personnel have been fit-tested and instructed in proper use.

2. The number of health care personnel within a room while care is being rendered should be the minimum needed for that care in order to reduce potential exposures to COVID-19 and other infections.

3. Providers and staff are required every day before they arrive at the office to 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). This attestation must be recorded in writing or in an electronic storage medium.

Policies and Procedures for <practice name> for providing care in the COVID-19 era (continued)

B. Workforce Safety (continued)

4. Practice leaders must attend to the emotional wellbeing of all providers and staff. Information, education and reassurance regarding measure to ensure safety must be given to all office personnel. Should anyone in the office display signs of emotional distress, that staff member should be offered a referral for support to an appropriate behavioral health provider.

5. Staff must endeavor to stay at least six feet apart consistently. If at any time this is not possible, all staff <6 feet from one another must be masked. (The workspace should be configured to permit that distancing if possible.)

C. Patient Safety

1. Patients and necessary companions are screened for COVID-19 symptoms (Fever, chills, cough, shortness of breath or difficulty breathing, sore throat, muscle aches, vomiting or diarrhea, new loss of taste or smell) before the visit. Should any of these be present, a clinician should triage this visit before the patient enters the office.

2. Intentionally omitted (not applicable).

3. Patients are told to arrive alone, if possible, or minimize the number of people accompanying them.

4. Patients and necessary companions must wear a mask before entering the office. If they do not have a mask, they must be met outside the office by a masked staff member who brings masks for both patient and companion.

Policies and Procedures for <practice name> for providing care in the COVID-19 era (continued)

D. Infection Control

1. Patient flow should be reconfigured to avoid patient-patient encounters.

2. Patients are brought into the office by a staff member who knows where other patients are and thus can avoid them. Patients are cared for throughout the encounter in one exam room. Patients are not to leave the exam room without clearance from a staff member who can check the corridor to make sure no other patients are there. The waiting room must be reconfigured to create >6 foot distances between seats, with other seats removed, blocked or labeled NOT FOR USE. All patients are requested to wear a mask or one may be provided by a staff member meeting them outside the office. Additional masks are made available in the waiting area.

3. Schedules are staggered to avoid patients arriving and leaving at the same time. In addition, staff check corridors to make sure a patient leaving an exam room has a clear path to the exit without encountering other patients. One daily session is dedicated to patients without clinical suggestion of COVID-19 disease; another is dedicated to patients who have suspected or confirmed COVID-19 infection.

4. Signs are posted in the waiting room and outside the entrance: "All patients and visitors must be masked. If you need a mask, ask any of our staff." Within common areas: "Cover your cough"; "Please maintain a distance of more than 6 feet from all other patients and staff"; "Clean your hands frequently with soap and water or with hand sanitizer." Signs should also indicate the location of Infection Control Stations containing masks, sanitizer and tissues.

5. Cleaning and disinfection: Visible soiling is always cleaned up before disinfection. A disinfectant approved by the EPA for use against SARS-CoV-2 is used at an appropriate dilution via spray or wipe, and left in contact with the surface for the necessary contact time per manufacturer's instructions. High-touch surfaces in the exam room or in any procedure room are disinfected after every patient. These include the exam table, chair, doorknobs, light switch, faucets, and anything else the patient likely touched during the visit. These surfaces are also cleaned with a standard surface cleaner whenever visibly soiled and at the end of the day, along with other high-touch surfaces like touch screens and keyboards. High touch surfaces in waiting rooms, staff areas, and any common areas are disinfected twice a day. Floors are cleaned at the end of every day with usual cleansing agents. Computer keyboards are covered with a plastic overlay so they can be easily disinfected.

APPENDIX C

Aerosal-Generating Procedures

Adapted from Tufts Medical Center, May 11, 2020

Examples:

- Intubation, extubation and related procedures such as manual ventilation and open suctioning
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
- Bronchoscopy
- Surgery and post-mortem procedures involving high-speed devices
- Non-invasive ventilation (NIV) such as bi-level positive airway pressure (BiPAP) and continuous positive airway pressure ventilation (CPAP)
- High-frequency oscillating ventilation (HFOV)
- High-flow nasal oxygen (HFNO), also called high-flow nasal cannula

These are the only procedures that would typically be done in an office setting:

- Induction of sputum
- Medication administration via continuous nebulizer (Metered dose inhaler use is an appropriate alternative that avoids aerosol generation)
- Some dental procedures (such as high-speed drilling)

Extended Use of Surgical Masks

Adapted from Tufts Medical Center, May 11, 2020

This guideline is for surgical mask usage in times of pandemic with supply shortage and is designed to safely increase the availability of face protection.

Extended Use -- The practice of wearing the same surgical mask for repeated close encounters with several patients without removing between patients.

- Wear surgical masks for repeated patient encounters (regardless of COVID-19 status). It is safe to wear the same surgical mask and eye protection with COVID-19 positive and COVID-19 negative patients provided you perform hand hygiene in between and do not touch the surgical mask or eye protection.
- If a patient's hands inadvertently touch eye protection or surgical mask that has been used in another patient's care, assist patient with performing hand hygiene.
- When practicing extended use of surgical masks, if inadvertently touched, perform hand hygiene.
- If you need to adjust the fit of the surgical mask without doffing it, perform hand hygiene before and after. If possible, don gloves to touch surgical mask.
- Once surgical mask is donned, keep it on for as long as possible, provided the conditions below which require mask change have not been met.
- Extended use of surgical mask is for up to 8 hours only.
- Surgical mask should be doffed and a new one donned if:
  - Wet, torn or soiled
  - Taking a break, eating or drinking

Reminders:

While extended use of surgical masks and eye protection is allowed, gowns and gloves must still be changed between patients

Tutorial Video (courtesy of Tufts Medical Center)

- Extended use of surgical masks

Extended Use of Eye Protection

Adapted from Tufts Medical Center, May 11, 2020

This guideline is for eye protection usage in times of pandemic with supply shortage and is designed to safely increase the availability of face protection.

Extended Use -- The practice of wearing the same eye protection for repeated close encounters with several patients without removing or reprocessing between patients.

- Wear eye protection for repeated patient encounters (regardless of COVID-19 status). It is safe to wear the same eye protection with COVID-19 positive and COVID-19 negative patients, provided you perform hand hygiene in between and do not touch the eye protection.
- If a patient's hands inadvertently touch eye protection that has been used in another patient's care, assist patient with performing hand hygiene.
- There is NO Reuse of eye-wear during a session - only Extended Use as described above.
- When practicing extended use of eye protection, if inadvertently touched, perform hand hygiene.
- If you need to adjust the fit of the eye protection without doffing it, perform hand hygiene before and after. If possible, don gloves to touch used eye protection.
- Once eye protection is donned, keep it on for as many patient encounters as possible.
- Extended use of eye protection is for one session only. At the end of the shift, dispose in trash OR drop into designated container for cleaning and disinfection as appropriate.
- Eye protection *can* be left on in common areas.
- It should be doffed (per below) and discarded in a reprocessing bin before eating or drinking, or if a break is needed.

Reminders:

While extended use of eye protection is allowed, gowns and gloves must still be changed between patients.

Tutorial Video (courtesy of Tufts Medical Center)

- Extended use of eye protection