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**

I. 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 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

[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.

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 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

[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.

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.

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).

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

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.

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

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.

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.