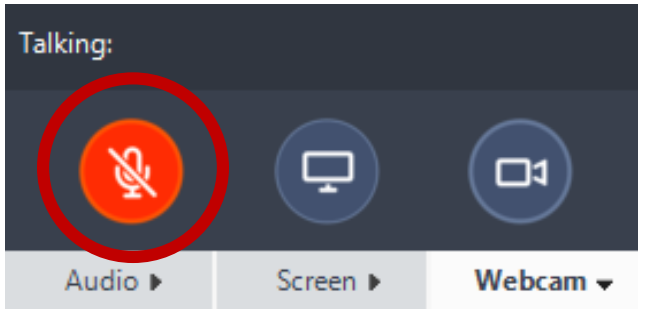
NEQCA Practice Reactivation Drop-in Q&A

Ben Kruskal, MD
NEQCA Medical Director
June 8, 2020

Please Mute



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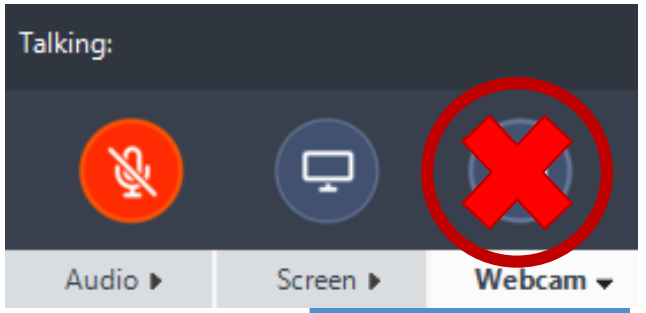

Agenda

- Phase 2 Reopening

- Practice Reactivation Guidelines & Infection Control: Requested topics

Phase 2 Reopening Guidelines from the State

- Whatever can be done by telehealth should STILL be done by telehealth.
- While routine care may now be provided in the office face to face if not possible to do via telehealth, providers should still prioritize more high-risk/urgent situations over routine care. (DPH suggested list)
- Defer non-essential care if PPE (or other essential materials) is in short-supply, or care would unavoidably include aerosol-generating procedures (high risk of Covid-19 transmission)
- For essential, non-deferrable invasive procedures, rooms must be left empty between procedures long enough to remove any possible airborne contamination.
- Elective cosmetic procedures may not be done in Phase 2

Phase 2: additional policies required

- Three additional written policies need to be formulated and attested to:
  - Prioritization policy for scheduling and delivery of non-urgent care must be established and applied consistent with healthy equity principles; the provider must attest that they are utilizing this policy in their determination of which patients should be seen in person.
  - Non-essential elective invasive procedure volume must be monitored to ensure it is not endangering PPE supply for essential procedures and services.
  - In addition to the infection control requirements of Phase 1, procedure rooms must be left empty in between procedures for a specified time frame necessary for sufficient air changes to occur to remove possible airborne contaminants, before disinfection

Phase 2: prioritization of clinical care-- principles

- <u>Whatever can be done by telehealth should STILL be done by telehealth</u>

- URGENT issues always come first (acute non-deferrable care for potentially serious issues)
- The prioritization policy should promote equitable access to care for all populations, without regard for patient's insurance type
- Defer elective non-essential care (procedures or other) that either:
  - Increases risk of possible Covid-19 transmission (e.g. aerosol-generated procedures)
  - Consumes scarce resources (e.g. PPE, or any vital item in short supply)
- Defer elective cosmetic procedures
- The prioritization can be modified by clinical judgement, but needs to be justifiable

Phase 2: prioritization of in-person care (continued)

- First tier
  - High priority preventive services (e.g. cancer screenings for HIGH-RISK patients)
  - Pediatric immunizations and other high preventive value care
  - Urgent procedures that would lead to high risk or worsening if deferred
- Second tier
  - Acute illnesses requiring in-person visit
  - Chronic illnesses
  - Patients with BH dx, disability, and/or SDOH risk factors regardless of insurance type
  - Adult preventive care which must be done in person
  - Progressive conditions which will worsen without intervention, or with sxs negatively affecting ADLs or QOL
  - Monitoring health status or progression of illness

Phase 2: Room air clearance after invasive procedures

- What are invasive procedures?
  - Anything involving skin incision
  - Injection into joint space or body cavity
  - Cystoscopy
  - Sigmoidoscopy
  - Excision and deep cryotherapy of malignant lesions
  - Invasive ophthalmic procedures
  - Oral/dental procedures such as tooth extraction
  - Podiatric procedures such as removal of ingrown nail
  - Skin or wound debridement
  - Colposcopy and cervical/endometrial biopsy

Phase 2: Room air clearance after invasive procedures (continued)

- For essential, non-deferrable invasive procedures, rooms must be left empty between procedures long enough to remove any possible airborne contamination.
- Time needed depends on ventilation rate (air exchanges per hour, ACH)
  - Find out the ventilation rate in your procedure (exam) rooms if possible
  - If not, typical patient care areas like exam rooms have 6-8 ACH
  - If perfect distribution of ventilation occurs, 99% clearance in 45 min at 6 ACH
  - https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

Phase 2: new attestation required

- New Phase 2 attestation form must be signed by senior person designated as compliance officer for the practice
- Practices with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance officer has clinical and operational control over the other locations.
- Health care providers must prominently post a copy of the signed attestation form at each of its facilities, clinics, and office locations.

Q&A

To Ask A Question

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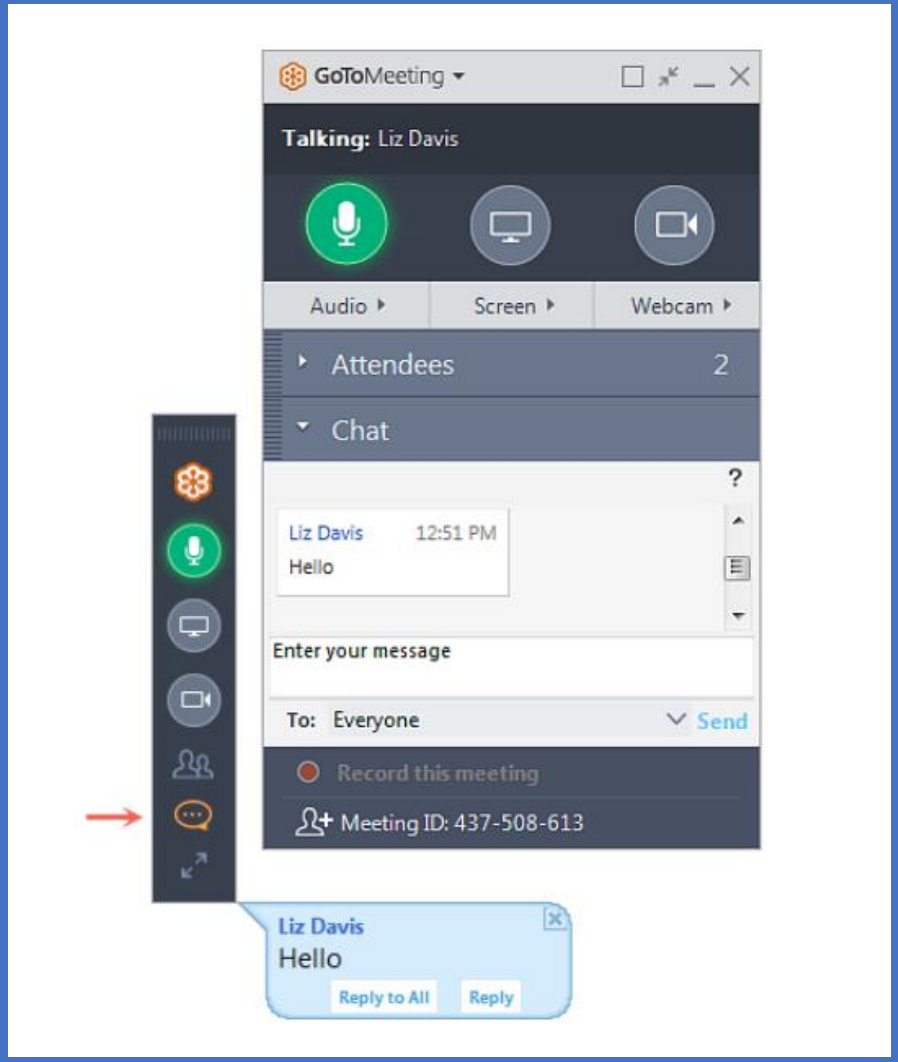

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NEQCA Practice Reactivation Guidelines

1. **Infection Control**
    1. **Personal protective equipment (PPE)**
    2. **Cleaning and disinfection**
    3. **Provider and staff health**
2. **Office Space Reconfiguration and Workflows**
3. **Telehealth**
4. **Reassuring Staff, Patients, and Families**
5. Human Resource Considerations
6. Financial Sustainability
7. **Additional Clinical Considerations**

Staff and Provider Health

Ben Kruskal, MD
NEQCA Medical Director
June 1st, 2020

Staff and provider health topics

- Daily symptom screen and attestation
  - Management of symptomatic HCWs
- HCWs with + test but no sxs
- Exposed but asymptomatic HCWs

Daily symptom screen and attestation

- Do you have or have you had since your last negative symptom screen any of the following symptoms?
- Fever, chills, cough, shortness of breath or difficulty breathing, sore throat, muscle aches, vomiting or diarrhea, new loss of taste or smell
  - If all answers are no, sign & record attestation to that effect
  - If +, requires evaluation by clinician (within practice? PCP? Other external evaluation?)
    - If symptoms are mild and non-specific, no known exposure history, and clear alternative diagnosis is apparent, may consider return to work and continuing to work with mask (effective for source control as well as health care worker protection)
    - Otherwise—testing for Covid-19

Health care worker exclusion from work due to symptoms

- May not work regardless of test result given low sensitivity of test (poor negative predictive value)
- Return to work per CDC/DPH guidelines
  - Test-based strategy: 2 negative PCR tests for COVID-19 at least 24 hours apart, afebrile and improved respiratory symptoms OR
  - Symptom-based strategy: 10 d after symptom onset with 3 days afebrile/no antipyretics and 3 days resolved respiratory symptoms

HCWs with + test but no symptoms at any time

- Return to work
  - 10 days after positive test
    OR
  - After 2 negative PCR tests at least 24 hours apart

Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with 2019 Novel Coronavirus (2019-nCoV) Infection or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations			
Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who was wearing a cloth face covering or facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves[a]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None

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HCP PPE: Not wearing gown or gloves[a,b]	Low	Self with delegated supervision	None

NEQCA Practice Reactivation Guidelines

1. **Infection Control**
2. **Office Space Reconfiguration and Workflows**
3. **Telehealth**
4. **Reassuring Staff, Patients, and Families**
5. Human Resource Considerations
6. Financial Sustainability
7. **Additional Clinical Considerations**

Reassuring Staff, Patients, and Families

- If patients don't feel safe, they will not come or come back.
- You may not get a chance to explain or reassure
- EveryTHING has to shout out "You're safe! We're doing it right!"
- Everyone, including staff, has to know how to DO it and how to EXPLAIN it

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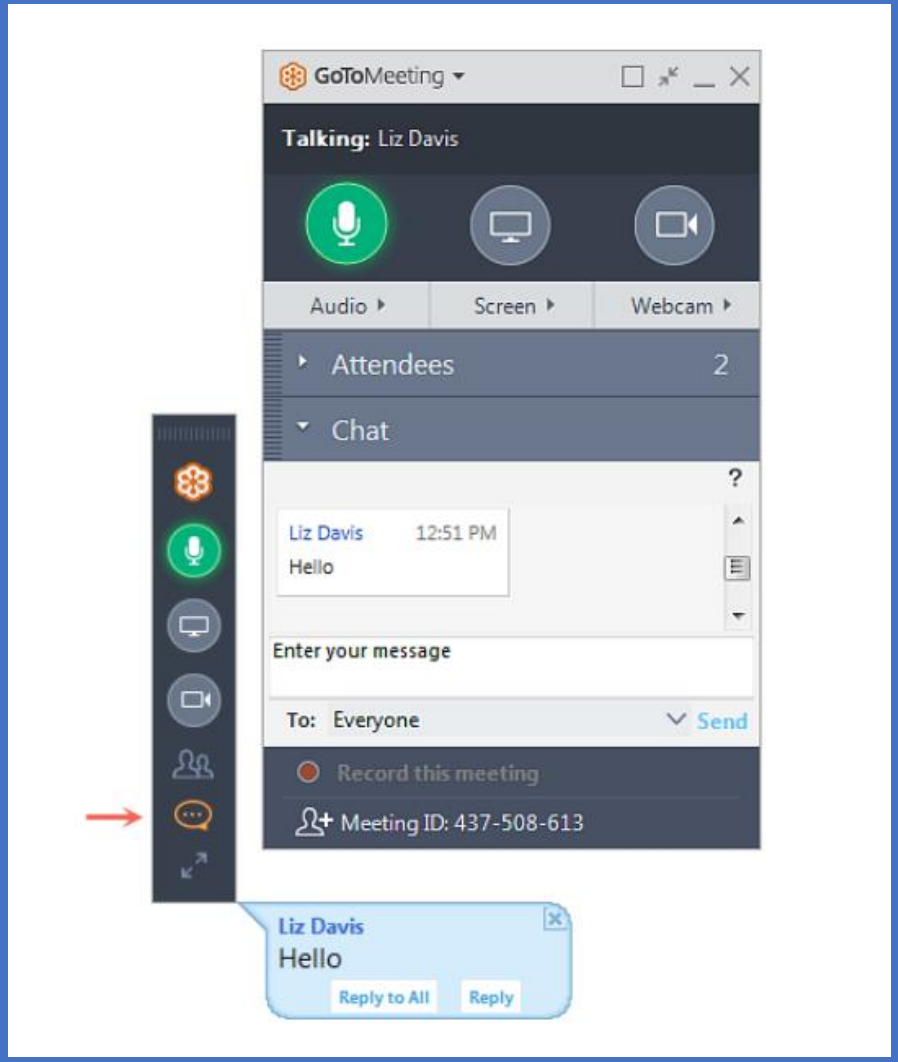

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Office space reconfiguration: waiting area

- Don’t expect to have a lot of people waiting at this stage of the outbreak—in fact, actively avoid it
- Seating
  - Chairs 6 feet apart
  - Remove extras or turn them to face the wall
  - Allow space for at least one wheelchair
- Infection Control stations (hand sanitizer, masks, tissues)
- Eliminate loose items (magazines, books, toys, clipboards, pens, business cards, pamphlets)

Office space reconfiguration: reception area

- If desk not enclosed, consider plexiglass barrier
- Markings on floor at 6 foot intervals if patients must line up

- Check-in/check-out process redesign
  - Contactless; phone, online?
  - Registration
  - Forms
  - Payment

Office space reconfiguration: Exam rooms and staff areas

- Exam rooms
  - Make sure everything is in there so patients don't need to leave, e.g. scale

- Staff areas (e.g. break room/kitchen/lounge/conference room)
  - 6 foot intervals? Infection Control Stations
  - No shared food (e.g. candy bowls, baked goods, etc)

Office space reconfiguration: corridors and signage

- Corridors and entryways
  - If two or more entries are available, designate one for sick and one for well

  OR Create one-way paths (one entry and one exit)
- Signage
  - Direction of patient flow
  - Social distancing indicators for elevators
  - Designate patient care areas (“Patient care: PPE required”) and non-patient care areas (Back office, staff areas) (“Non-patient care: No PPE except personal masks”)
  - Throughout:
    - “Please keep mouth and nose covered at all times; if you need a mask, ask one of our staff”
    - “Cover your cough”
    - Infection control stations

Office space reconfiguration: principles

- There is not one right way
- Every office is different; many of these are meant as inspirations rather than requirements
- Adapt these ideas to your setup
- Principles
  - Keep people (patients and staff) away from each other by 6 feet when possible
  - Avoid direct contact
  - Reduce opportunities and needs for touching surface and objects
  - Make it easy to do the right thing

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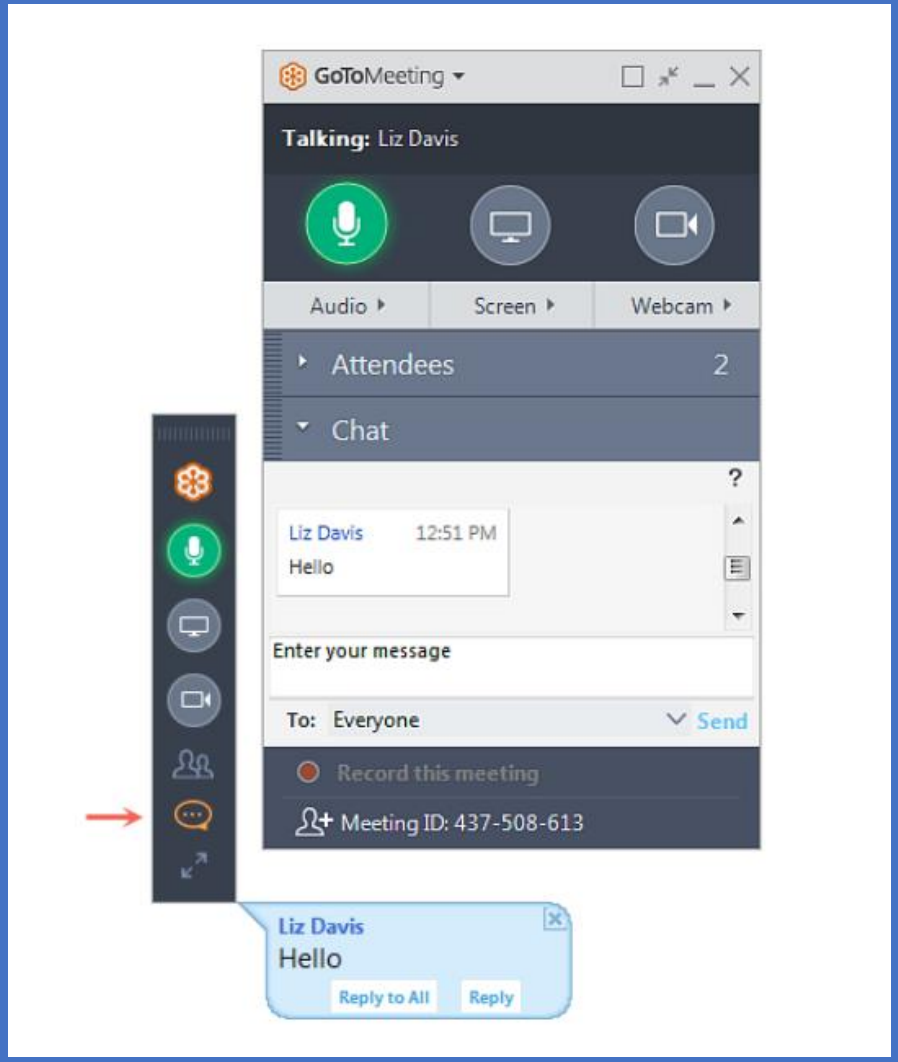

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Scheduling and patient prioritization

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NEQCA Medical Director
May 27, 2020

Scheduling

- If there are multiple providers, consider:
  - One provider doing telehealth from home and one in the office seeing in-person visits, switching off

    OR
  - expanded hours so providers are in the office together for less time, and fewer patients in the space at the same time
- Telehealth visits with f/u BRIEF in-person visits for
  - Targeted physical exam
  - Immunizations
- Discourage walk-ins

Scheduling (continued)

- Lengthen in-person appointment slots to allow for room cleaning/disinfection, PPE donning/doffing, etc
- Half-day dedicated to patients without any symptoms suggesting Covid-19; the other half, only for patients with compatible symptoms
- Review appointments cancelled for pandemic to rebook, consider telehealth vs in-person

Priority appointments: Use this list, tempered by clinical judgement

- High risk issues, new, or deferred care (e.g. workup for issues of high concern interrupted)
- Management of conditions likely to become serious if not treated promptly
- Chronic disease management for brittle/poorly controlled conditions
- Well child care for young infants
- Immunizations
- Cancer screening for high risk patients
- Long-acting reversible contraception

Confirmation calls

- Not more than 48 hours in advance
- Orient patient to new office procedures and flow
- Request they arrive in a mask
- Request they wait in car or other outside location, call to notify when they've arrived
- Request no additional people unless necessary (child, demented adult, need for physical support, etc) and then one only
  - Offer speakerphone presence for family members and/or interpreter
- Screen for symptoms possibly indicating Covid

Before/at the beginning of the visit

- Before the visit: Do “paperwork” online or by phone in advance
- When patient calls to say they’ve arrived, have them wait for masked staff member with a few masks (for patient and a companion if they don’t have their own). The patient should be asked the Covid-19 symptom screening questions again, as should the companion if any.
- The patient is escorted directly to the exam room. Any additional check-in procedures not already completed can be done in the exam room, ideally by contactless means.

At the end of the visit

- Conduct any check out business online or by phone if possible; if not, complete in the exam room. Patient should stay in exam room until staff member tells them the path is clear and they can exit the practice.

Telehealth

Ben Kruskal, MD

NEQCA Medical Director

05/27/2020

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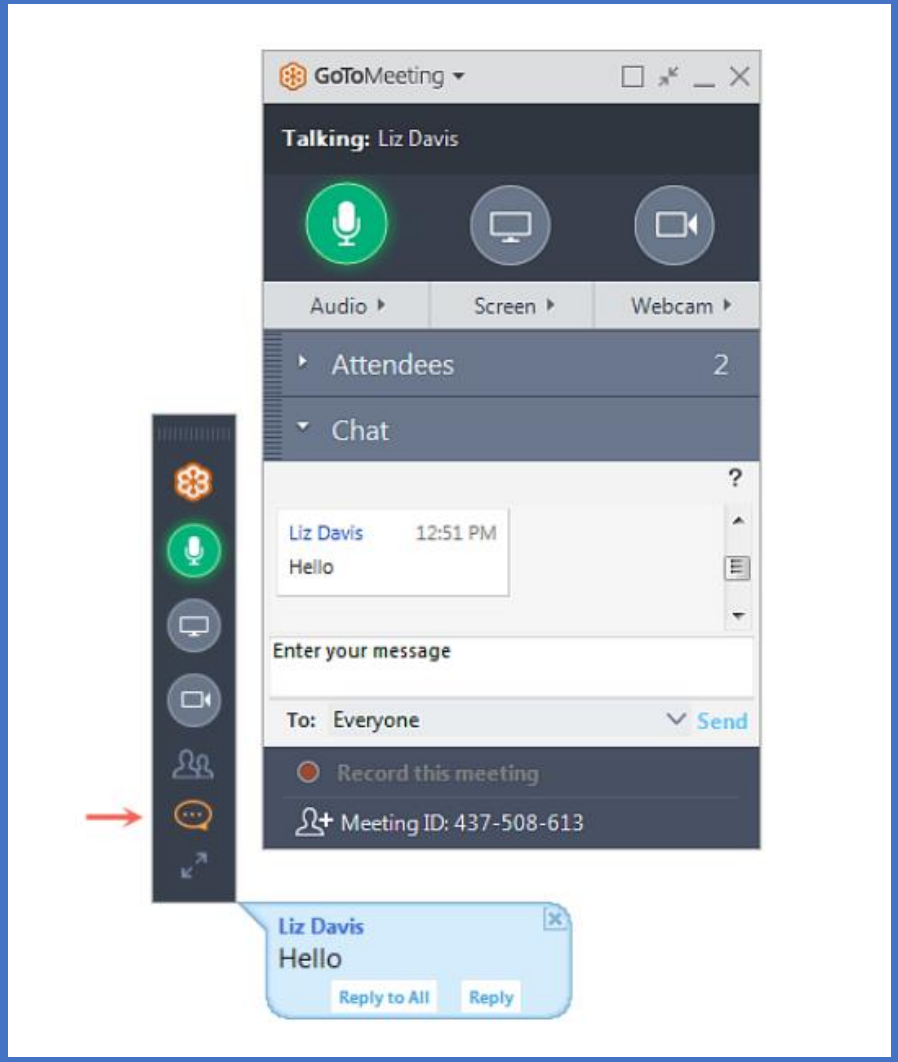

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Telehealth: practice setup

- Choice of platform
- Inform patients and the community: multimodal communication
- Technology; e.g. two screens? Add third party (family, interpreter)?
- EMR note template for telehealth
- Schedule visit types and template
- Cluster or intersperse telehealth and face to face visits?

Telehealth: filling your schedule

- Looking backwards: patients cancelled due to pandemic?
- Looking forwards: scheduled face to face visits that should be converted to telehealth?
- Triage protocols for office staff to know what should/could be telehealth and what should/must be face to face

Staff roles in Telehealth

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

Telehealth

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

Q&A

Infection Control in the Ambulatory Setting: Quick Review

Ben Kruskal, MD

Medical Director

Infection control: staff and patients must feel safe as well as be safe

- The degree of knowledge and expertise must be far above what is necessary for the work itself
- You must inspire confidence in patients and staff that you've thought of everything, and done everything right
- Staff too must be able to inspire confidence in patients in the same manner; be able to answer questions confidently and correctly

Hand Hygiene:
soap and water vs hand sanitizer

- Equally good if done well
- Easier/faster to do hand sanitizer well
- HOWEVER, hand sanitizer does not clean, only disinfects
  - Disinfection doesn't work well on dirty things
- Soap and water cleans AND disinfects
- Common diarrhea-causing pathogens for which soap and water is better
  - Norovirus
  - C. diff

CONTACT

Impetigo

MRSA

AIRBORNE

Measles

Varicella

TB

DROPLET

Influenza

Mumps

Pertussis

Diarrhea

TRANSMISSION-BASED PRECAUTIONS

STANDARD PRECAUTIONS

HIV and other blood borne

All pts treated as if might transmit

UNIVERSAL DROPLET PRECAUTIONS

Covid-19

All pts treated as if might transmit

Droplet precautions/PPE

- Surgical mask
- Gloves
- Gown only needed for splash/splatter/direct torso-to-torso contact
- Enhanced droplet protection for splash/splatter: + Eye protection

Disinfection and SARS-CoV-2/Covid-19

- Disinfection & sterilization don't work well on dirty surfaces

- The virus is very sensitive, can be killed easily
  - Killed by soaps/detergents, most cleansing agents
  - Killed by heat
  - Killed by any common disinfectant

  - EPA has a list of >40 products effective against this virus