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System-wide Recovery Guidelines

Team: Ambulatory Specialty Care
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I. Guidelines for Operational Readiness & Capacity Management

a. Clinic Capacity based on a Phased Reopening:

- Prior to resuming activities, each discipline will review with administration and the appropriate Supply Chain personnel the current availability of staffing and resources, respectively, that will be needed to meet the required conditions for clinic opening (outlined below). Once these conditions are satisfied, reopening ambulatory activity in a step-wise, phased approach is recommended.
- Many frameworks are available to organize a staged increase in clinical activity to confirm that patient volume does not outstrip available resources. This staging will be dependent on the current activity during the acute phase of the pandemic as some clinics have remained partially operational while others have paused all activity. Physician leads and operations managers may find it useful to review the following frameworks to aid and structure their decision making: BIDMC phasing (Phase 1: Urgent, Phase 2: Semi-Urgent, Phase 3: Routine, Phase 4: 100%+ of budgeted visits), ACS approach (acute phase, early recovery, late recovery)[1], and BILH staged reopening of capacity (25%, 50%, 75%). The appropriate mode of engagement with the patient (telehealth versus in-person visit) is an important additional consideration.
- Integration of clinical urgency with operational readiness may be addressed with a prescribed staged opening and network capacity/space (e.g., shared clinics as an interim step) in phases: For example:
  1. Phase 1 (at the height of the pandemic) – Emergent cases
  2. Phase 2 (with expansion of clinic services, including non-emergent care) – Patients with medical urgency or needed longitudinal care or visits with a low-visit footprint (e.g., telehealth, blood work, screenings)
     - i. A plan to include standard patient evaluations in high-risk patients
     - ii. Routine screening for serious medical conditions (e.g., lung cancer screening)
  3. Phase 3 (with operations at full capacity modified for the new environment) – Routine (e.g., bariatric patient, annual “well” patient)
- A process of staged resumption of activity is anticipated for the network that recognizes the external factors associated with the pandemic, the need for patients to undergo in-person evaluation or treatment based on medical necessity, the relative requirements for delivery of care, and the infrastructure of the individual clinic areas to provide necessary safeguards as

[1] ACS Guidelines for Triage and Management of Elective Cancer Surgery Cases During the Acute and Recovery Phases of Coronavirus Disease 2019 (COVID-19) Pandemic. https://www.facs.org/-/media/files/covid19/acs_triage_and_management_elective_cancer_surgery_during_acute_and_recovery_phases.ashx

outlined below. Clinics should open in a phased approach based on Operational Readiness, meeting defined operational criteria (below) before increasing clinic capacity. Medical and operations leaders of clinics will be guided by system and institutional guidance about permissible levels of activity, which in turn will depend on local and state orders reflective of the state of the pandemic environment.

- The Commonwealth is providing up-to-date metrics on the state of the pandemic. Examples of key indicators of reduction of the external threat posed by the pandemic are:
  (1) Downward trend in 14 day hospitalization rate of patients affected by COVID-19 and
  (2) Decreasing percent positive PCR tests among all daily new COVID-19 PCR tests reported [Massachusetts Department of Public Health COVID-19 Response Reporting]
- Principles of medical prioritization are outlined later in this document and are not germane to this section which considers operational readiness. Please keep in mind that medical prioritization is a critical process to cut overall patient volume back to a level that can be accommodated while minimizing adverse effects of deferring other care.

b. Operational Readiness Criteria:

Spacing and Geographic Footprints in the Clinic

- Social distancing should be maintained in the waiting room and patient care areas
- Geographic layout of the clinic will need to be modified to limit patient density in the waiting room, evaluation, and treatment areas
- Patients may be asked to wait remotely until called in for evaluation
- Creative use of and modification of conventional scheduling practice may offers clinics several tactics to optimize safety by reducing the number of patients that are on premises at one time. Clinics should select the appropriate mix of these example practices:
  - Consider ratio of providers to rooms, and number of providers seeing patients in a given space at one time. Example: scheduling no more than 2 providers seeing patients at one time with 3 rooms available per provider. No more than 3 visits per hour.
  - Consider offering designated service hours for high-risk populations: for instance, symptomatic patients with fever, cough, influenza-like illness (ILI) symptoms or suspected COVID-19 positive patients at the end of the day (to achieve some separation from other patients, and afford more thorough room air turnover overnight and terminal cleaning at the end of the day).
  - Clinics should consider operating expanded weekly schedules, e.g., operating 6 days/week and/or offering expanded hours. This will require careful assessment matching availability of staff and support services.
  - Consider offering more exam rooms per care team/provider per session to allow for appropriate cleaning between patients.
  - Consider multidisciplinary care in COVID-19 care areas versus non-COVID-19 care areas, with providers from multiple specialities seeing the same patients in the same space.
  - Consider creating dedicated COVID-19 rooms within a clinic, COVID-19 clinic sessions, or COVID-19 days to consolidate care, reduce PPE usage under extended use protocols, and more efficiently handle cleaning needs.

PPE (Availability, Burn Rate, Preservation, Redundancy)

- Clinics should adhere to appropriate PPE usage for staff and patients in line with BILH policies.
- The current recommendation is that staff maintain the basic principle of Standard precautions with all patient encounters as well as staff interactions. This involves the wearing of surgical masks in the clinic at all times, with the use of eye protection for all patient care, and the addition of gloves and a gown for care of patients with suspected or confirmed COVID-19. If aerosol-generating procedures are performed, a N95 respirator should be used. The specific recommendations are likely to undergo evolution.
- Patients and essential escorts will be asked to wear cloth face coverings or masks during the visit. During the reminder call and symptom and exposure screen 48 hours prior to the appointment, patients will be asked to bring a face covering or mask with them, if possible. For patients and escorts who arrive without masks, one will be provided to them.
- PPE preservation through extended use and reuse per current recommendations is an important pillar of ensuring that adequate levels of PPE remain available
- Clinics should anticipate PPE usage/burn rate based on staffing and anticipated in-person visit volume & report usage via manager/local leadership up to local incident command
- Clinics should stock adequate PPE supply on-site for staff, patients, and escorts
- All care team members should be trained on proper donning and doffing techniques
- Clinics operations teams should define adequate and safe levels of PPE inventory based on burn rate
- If resumption of care results in an unsustainable increase in the burn rate of PPE, clinic operators may receive feedback that operations may need to be held steady or throttled back. This dialog will ensure that clinical activity can be aligned with the prevailing reality of the PPE supply situation. Supply Chain and operations leaders should regularly monitor availability metrics (e.g., 30 days on hand) and redundancy metrics (e.g., percentage of staff using N95s that have been fit-tested to a 2nd brand)
- Adapt preservation measures (and contingency plans) in coordination with leads overseeing the local supply situation.
- It cannot be overemphasized that safe care is of paramount importance. If patients and/or staff cannot be adequately protected from infection as a result of inadequate PPE supplies, operations need to be adapted to ensure that this premise is kept.

Protocols for Disinfection

- Protocols for cleaning and disinfection of clinic areas is a requirement for resuming operations. Frequency and process of cleaning the clinic spaces should adhere to BILH protocols.
- Daily general cleaning may involve daily cleaning of all patient care, staff, and public spaces by Environmental Services (EVS) and appropriate disinfection of each room and treatment space between each patient encounter by the clinic staff.
- EVS support, clinic staffing, and availability of cleaning materials should be confirmed prior to resumption of clinic operations.

Protocols for Patient and Essential Escort Symptom Screening

- Patients should undergo symptom and exposure screening, as outlined in the BILH policy, by phone or electronically 48-72 hours prior to their appointment
  - Patients who have a positive symptom or exposure screen should be considered for testing and/or delay of their appointment
  - Patients will be screened again upon arrival at the point of care
  - Patients with a positive screen who come to clinic should be seen using Droplet and Contact Precautions
- Essential escorts should undergo symptom and exposure screening, per BILH policy, upon entry to the facility
  - Escorts who have a positive symptom or exposure screen should be asked to leave the facility and recommended for evaluation
  - Escorts who leave the facility should provide a phone number where they can be reached to pick up the patient
  - Clinic or facility staff should assist the patient when their escort is unable to accompany them to their clinic visit

c. Operationalizing of Infection Control Guidelines:

Staff Testing & Safety

- Continue employee symptom screening and monitoring system per existing policies and procedures
  - Adhere to BILH policies regarding working when symptomatic
  - Develop redundancy in staffing model in the event of employee illness
  - Educate staff about how to keep their families safe
- Adhere to current BILH return to work policy
- Continue to use remote work where possible (e.g., providers working shifts/days of telehealth remotely), and leverage ability of clerical and scheduling staff to tele-commute in accordance with applicable institutional and system policy
- Optimize infection prevention practices in break room, lunch room, conference rooms, and at clinic front desk
  - Maintain proper social distancing in these areas
  - If not possible due to space constraints, implement a sign-up rotation
  - Attention to thorough hand hygiene
  - Disinfect countertops, microwave, etc after use
- Implement standardized team huddles twice per day to foster situational awareness and solidarity

Staff Training, Coordination, & Readiness

- Ensure education of staff as to optimal infection control practices. Dissemination of BILH published guidelines for masking, patient screening, staff symptom attestations, hand hygiene, disinfection of shared medical equipment, donning and doffing PPE, and PPE extended use and reuse protocols [BILH COVID-19 Materials]
- Foster situational awareness, training and solidarity via regular team meetings Create opportunities for regular review of clinic practice, review of experience, and opportunity for systems improvements.
- Clinics should consider identifying team members for three key tasks:
  1. "Flow buster" (should raise a flag if patient or staff safety becomes compromised due to increased volume)
  2. Infection Control Liaison/PPE expert (hand hygiene, equipment disinfection, donning & doffing, inventory monitor)
  3. Telemedicine (in-clinic subject matter expert for all matters pertaining to telemedicine)
- Environmental Services training for use of signage for equipment/exam rooms to designate "clean/not yet cleaned" services.

d. Optimizing Clinic & Network Capacity:

- Clinics across the health system will likely return to (new) normal operations at different paces. Clinics should leverage local operational leadership and incident command structures to help manage prioritization and sites of care across clinics and across hospitals.
  - Identification of specialized expertise needed to meet a patient's needs is a key input to leverage network capacity.
  - In case of inability of local recovery incident commands or medical directors to find capacity in their facility, they should consider escalating the issue to an operational leadership group (e.g., BILH Recovery Incident Command) or medical director to evaluate whether system-wide capacity exists for high-priority cases.
- The BILH will endeavour to facilitate the flow of patients into off-site locations if they cannot be accommodated within the primary hospital, will promote use of shared physical clinic space and infrastructure by multiple provider teams as feasible, and will leverage underutilized clinics/spaces (if applicable). A designated network-based committee should support these efforts.
  - Example: A time-critical, specialized interventional radiology treatment can't be provided in a specific service location care due to workforce and facility constraints. The local subject matter experts/clinicians are likely to have knowledge about potential alternative sites of care. They are encouraged to assist with arranging a transfer of such care, after consulting with their counterparts at the alternative site. This will often be done on a patient-by-patient basis, since complex medical, skillset, and logistical considerations are likely to arise.
  - Local clinics by design have a limited situational awareness of what is going on at other locations and in other service lines. This requires an integration function at the system level and/or coordination between institutional/site leaders. They are in a position to identify and connect clinical/ops leaders of similar or complementary clinics and services to facilitate coordination and patient load balancing.

- Progress of recovery may be tracked by reporting system-wide metrics. While this is challenging to accomplish across diverse electronic health records and business intelligence systems, there are some potential key metrics such as recovery volume vs. weekly historical run rate. Taking into consideration that clinics will not be able to reach pre-COVID-19 capacity right away, it may also be useful to report the gap between utilization and actual current capacity since historic capacity may not presently be achievable.