Beth Israel Lahey Health

System-wide Recovery Guidelines

Team: Ambulatory Specialty Care
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II. Guidelines for Patient Prioritization

a. Prioritization Criteria:

- Ambulatory clinics and services should consider prioritization along two main dimensions:

(1) <u>Patient (medical) prioritization</u> based on criteria of patient risk vs. medical need
<u>Patient medical stratification</u>: Consideration should be given to the clinical urgency, including prognosis of a particular patient's condition, and impact thereof on the patient's quality of life. Risk-benefit analysis plays an important role when considering individual cases. The following guiding principle is offered for consideration by the ACR: "If the risk of illness or death to a healthcare worker or patient from healthcare-acquired COVID-19 is greater than the risk of illness or death from delaying […] care, then care should be delayed; however, if the opposite is true, the […] care should proceed in a timely fashion. The risk from healthcare-acquired COVID-19 can be made very low for most […] examinations and […] procedures if appropriate safety measures are in place (screening, testing, infection control processes, PPE, etc.). Decision-making will be guided by attempts to estimate these risks.

In the initial phase of resumption of activities, patient medical conditions that require urgent evaluation and treatment should be prioritized. Those patients who require in person longitudinal assessments for complex medical conditions for which delays in assessment pose significant risk should also be prioritized. The relative risk of delay in treatment or evaluation as compared to the risks from outside exposures will need to be carefully considered for each patient disease category and situation reflecting on the disease process and risk from COVID-19 infection. Each discipline should consider creating a schema to define prioritization within their disease specialty and a forum for discussion and evaluation within the specialty to address the issues posed by individual patients. Practices should do their best to determine the risk to healthcare workers and patients of developing illness or death from healthcare-acquired COVID-19 in their local environment, as well as the patient-specific risk of illness or death from postponing an examination or procedure, and then use that information to guide the re-engagement of non-urgent […] care. In this determination, the probability of negative outcomes (from COVID-19 and non-COVID-19 disease) should take precedence. Patient-specific risk is best determined through collaboration between […] providers."[1]

(2) <u>Operational prioritization</u>: As outlined above, determination of appropriate clinic volume will be dependent on the hierarchy of medical urgency and evaluation as determined by the conditions of the pandemic and the need to provide care within the specific discipline.

[1] Davenport MS, Bruno MA, Iyer RS, Johnson AM, Herrera R, Nicola GN, Ortiz D, Pedrosa I, Policeni B, Recht MP, Willis M, Zuley ML, Weinstein S, ACR Statement on Safe Resumption of Routine Radiology Care During the COVID-19 Pandemic, Journal of the American College of Radiology (2020), doi: https://doi.org/10.1016/j.jacr.2020.05.001.

As outlined below, clinic volume will also be dependent on the needed infrastructure and conditions to care for patients in a setting that minimizes risk of exposure to COVID-19 infection. These two guiding principles will be used to determine the assignment of patients to in-person as compared to remote (telehealth) visits. Clinics should consider the "visit footprint": which visits/treatments can be done sooner than later, and at scale, versus other activities which have remaining operational interdependencies that cannot be met at scale. In the setting of clinical need that is not able to be met due to operational constraints, a process for referral to other sites within BILH will be provided.

b. Prioritization Process & Virtual Care Considerations:

In providing these principles, we are mindful of the heterogeneity across specialty practices (in current operation, capacity, etc.) and the wide range of patient needs. We encourage each clinic to prioritize patients locally and to collaborate with the local incident command, medical directors, and complementary service line leaders in optimizing network capacity and off-site space.

(1) Virtual Care Considerations during Prioritization: Before prioritizing in-person visits, clinics should develop processes to review patient master lists and orders within EMRs for determination of appropriateness of visits to be conducted at the facility as compared to remotely via telehealth.

a. Since telehealth and in-person visits will both require clinic staff/resources, both types of visits need to be considered in parallel. While the "footprint" of a telehealth visit (on-site resource utilization, infection risk) is smaller, significant support may be needed to provide patient education and other requirements via telehealth visits. The medical appropriateness and ability and preference of patients to engage with the provider team in this way should be assessed.

b. The appropriate leveraging of telehealth evaluations is encouraged when feasible and appropriate. Examples may include cases that haven't been previously managed virtually (e.g., nutrition, chronic pain), as well as those which require only a very focused and simple interaction.

c. Telehealth visits will need to be integrated into the larger process of patient evaluation and follow up as patients will likely require a combination of in-person and remote assessments. A process to manage longitudinal care in this setting should be established to avoid disruption on continuity.

(2) Prioritization Process: The prioritization process requires the establishment of a defined algorithm within each discipline along with a process for regular review of pending clinical items/patients while fitting in net new work that arises from referrals and initial patient presentation. Providers may need to decide on a case-by-case basis how long some visits and treatments can be postponed before becoming urgent or emergent. The order of appointments and care may need to be re-arranged accordingly. The optimization of these processes will require an iterative process as experience may direct best practices. Clinics are encouraged to foster a continuous improvement mind-set. Sharing of best practices across BILH is welcome and will be supported. In managing this process, clinics are encouraged to consider:

a. The clinic's provider team and operations team need to work collaboratively to achieve optimal prioritization within a clinic.

b. Challenging situations arbitrating resource allocation between individual patients or groups of patients (e.g., biopsies, cancer patients) may arise. Member clinics and institutions should establish an escalation process for input and adjudication (e.g., through the local medical director or incident command).

c. In prioritizing patients, clinics should also consider coordination with ancillary services (e.g., imaging, labs) that may be needed to support a complete encounter. This represents an opportunity to recognize bottlenecks in required support, allowing clinics to manage expectations of patients and to schedule accordingly. If clinics are unable to secure necessary services at a required level, local medical directors or incident command may need to assist in synchronizing priorities across service lines. Ideally, this would happen before patient care is scheduled and negatively impacted by lack of coordination or availability of required resources.

d. Lead providers act as liaisons between individual clinics and the local medical director in these instances.